

**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**

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A B I L L

To amend sections 3903.81, 3907.14, 3921.10, 3921.13, 1
3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 2
3921.31, 3921.33, 3922.01, 3922.02, 3922.03, 3
3922.04, 3922.05, 3922.06, 3922.09, 3922.10, 4
3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 5
3925.08, to enact new section 3921.35 and sections 6
3921.101 and 3921.191, and to repeal section 7
3921.35 of the Revised Code to make changes to the 8
law regulating fraternal benefit societies, the 9
laws regulating insurance company investments, and 10
the law regulating adverse benefit determinations. 11

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

Section 1. That sections 3903.81, 3907.14, 3921.10, 3921.13, 12
3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, 3921.33, 13
3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 3922.09, 14
3922.10, 3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 3925.08 15
be amended and new section 3921.35 and sections 3921.101 and 16
3921.191 of the Revised Code be enacted to read as follows: 17

Sec. 3903.81. As used in sections 3903.81 to 3903.93 of the Revised Code:	18 19
(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.	20 21 22
(B) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions.	23 24 25
(C) "Company action level RBC" means the product of 2.0 and an insurer's authorized control level RBC.	26 27
(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.	28 29 30 31
(E) "Domestic insurer" means any insurance company organized under Chapter 3907. or 3925. of the Revised Code.	32 33
(F) "Foreign insurer" means any insurance company licensed under section 3909.01 or 3927.01 of the Revised Code.	34 35
(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>	36 37 38 39 40 41
(H) "Mandatory control level RBC" means the product of .70 and an insurer's authorized control level RBC.	42 43
(I) "NAIC" means the national association of insurance commissioners.	44 45
(J) "Negative trend" means a negative trend over a period of	46

time for a life or health insurer as determined in accordance with 47
the trend test calculation included in the RBC instructions. 48

(K) "Property and casualty insurer" means any insurance 49
company that has a certificate of authority pursuant to section 50
3929.01 of the Revised Code. "Property and casualty insurer" does 51
not include monoline mortgage guarantee insurers, financial 52
guarantee insurers, or title insurers. 53

(L) "RBC" means risk-based capital. 54

(M) "RBC instructions" means the RBC report, including 55
risk-based capital instructions, as adopted by the NAIC and as 56
amended by the NAIC from time to time in accordance with the 57
procedures adopted by the NAIC. "RBC instructions" shall also 58
include any modifications adopted by the superintendent, as the 59
superintendent considers to be necessary. 60

(N) "RBC level" means an insurer's company action level RBC, 61
regulatory action level RBC, authorized control level RBC, or 62
mandatory control level RBC. 63

(O) "RBC plan" means a comprehensive financial plan 64
containing the elements specified in division (B) of section 65
3903.83 of the Revised Code. 66

(P) "Revised RBC plan" means an RBC plan rejected by the 67
superintendent of insurance and then revised by an insurer with or 68
without incorporating the superintendent of insurance's 69
recommendation. 70

(Q) "RBC report" means the report required by section 3903.82 71
of the Revised Code. 72

(R) "Regulatory action level RBC" means the product of 1.5 73
and an insurer's authorized control level RBC. 74

(S) "Total adjusted capital" means the sum of both of the 75
following: 76

(1) An insurer's statutory capital and surplus as determined 77
in accordance with the statutory accounting applicable to the 78
annual statements prepared on a form adopted under section 3901.77 79
of the Revised Code, as required to be filed by sections 3907.19, 80
3909.06, and 3929.30 of the Revised Code; 81

(2) Such other items, if any, as the RBC instructions may 82
provide. 83

Sec. 3907.14. The capital, surplus, and all accumulations of 84
every domestic life insurance company shall be invested as 85
follows: 86

(A) A domestic company may acquire, hold, and convey real 87
estate: 88

(1) Which has been acquired or is acquired for its principal 89
offices, or which is used in connection therewith, provided that 90
it shall not invest more than five per cent of its admitted assets 91
on the preceding thirty-first day of December in such real estate; 92

(2) Which has been mortgaged to it in good faith by way of 93
security for loans previously contracted or for money due; 94

(3) Which has been conveyed to it in satisfaction of debts 95
previously contracted in the course of its dealings, or which it 96
may receive in or on account of an exchange for real estate 97
acquired in its operations; 98

(4) Which it has purchased at sales under mortgages and on 99
any legal process in connection with its investments or under 100
decrees obtained or made for such debts; 101

(5) Which is acquired, owned, or held for the purpose of 102
developing, improving, or otherwise utilizing such real estate for 103
the production of income, without restriction or limitation as to 104
time, and may acquire, lease, hold, and manage personal property 105
used in connection therewith. No investments in real estate to be 106

used primarily for recreational, agricultural, or mining purposes 107
shall be made under authority of division (A)(5) of this section 108
and except for investments authorized under divisions (A)(1), (2), 109
(3), and (4) of this section, no domestic life insurance company 110
shall invest in real estate under divisions (A)(5) and (R) of this 111
section a sum exceeding in the aggregate ten per cent of its 112
admitted assets on the preceding thirty-first day of December. 113

All real estate specified in divisions (A)(3) and (4) of this 114
section, which is not necessary for its accommodation in the 115
convenient transaction of its business, shall be sold by the 116
company and disposed of within five years after it has acquired 117
the title to such real estate or within five years after such real 118
estate has ceased to be necessary for the accommodation of its 119
business, unless the company procures the certificate of the 120
superintendent of insurance that its interests will suffer 121
materially by a forced sale of the real estate, in which event the 122
time for the sale may be extended to such time as the 123
superintendent directs in such certificate. 124

(B) A domestic company may acquire, hold, and convey tangible 125
personal property or interests therein for the production of 126
income, provided no domestic company shall invest in excess of two 127
per cent of its admitted assets as of the preceding thirty-first 128
day of December under this division. 129

(C) In loans and liens upon the security of its own policies, 130
not exceeding the reserve or present value of the policies, 131
computed according to any standard authorized by law or according 132
to such higher standard as the company has adopted and maintains 133
on the policy, the reserve being the amount of debts of the life 134
insurance company by reason of its outstanding policies in gross, 135
which may be so treated in the returns for taxation made by it; 136

(D) In bankers' acceptances and bills of exchange of the 137
kinds and maturities made eligible by law for rediscount with 138

federal reserve banks, provided that such acceptances and bills of 139
exchange are accepted by a bank or trust company incorporated 140
under the laws of the United States or of this state or any other 141
bank or trust company which is a member of the federal reserve 142
system; 143

(E) In equipment trust obligations or certificates, security 144
agreements, or other evidences of indebtedness entered into 145
directly or guaranteed by any company operating wholly or partly 146
within the United States or Canada, provided that the debt 147
obligation is secured by a first lien on tangible personal 148
property which is purchased or secured for payment thereof and the 149
debt obligation is repayable within twenty years from the date of 150
issue in annual, semiannual, or more frequent installments 151
beginning not later than the first year after such date; 152

(F) In bonds issued by or for federal land banks and any 153
debentures issued by or for federal intermediate credit banks 154
under the "Federal Farm Loan Act of 1916," 39 Stat. 360, 12 155
U.S.C.A. 641 as amended; any debentures issued by or for banks for 156
cooperatives under the "Farm Credit Act of 1933," 48 Stat. 257, 12 157
U.S.C.A. 131 as amended; 158

(G) In bonds issued under the "Home Owners' Loan Act of 159
1933," 48 Stat. 128, 12 U.S.C.A. 1461; 160

(H) In notes, bonds, debentures, or other such obligations 161
issued by the federal housing administrator; 162

(I)(1)(a) In bonds or other evidences of indebtedness, not in 163
default as to principal or interest, which are valid obligations 164
issued, assumed or guaranteed by the United States, by any state 165
thereof, by the Commonwealth of Puerto Rico, by any territory or 166
insular possession of the United States, or by the District of 167
Columbia, or which are valid obligations issued, assumed, or 168
guaranteed by any county, municipal corporation, district, or 169

political subdivision, or by any civil division or public 170
instrumentality of such governmental units, if by statutory or 171
other legal requirements such obligations are payable, as to both 172
principal and interest, from taxes levied upon all taxable 173
property within the jurisdiction of such governmental unit; 174

(b) In bonds or other obligations issued by or for account of 175
any such governmental unit having a population of five thousand or 176
more by the latest official federal or state census, which are 177
payable as to both principal and interest from revenues or 178
earnings from the whole or any part of a publicly owned utility 179
supplying water, gas, sewage disposal facility, or electricity, or 180
any or all of them, provided that by statute or other applicable 181
legal requirements, rates from the service or operation of such 182
utility must be fixed, maintained, and collected at all times so 183
as to produce sufficient revenues or earnings to pay both 184
principal and interest of such bonds or obligations as they become 185
due; 186

(c) In any bonds or obligations payable from and secured by 187
revenues of the United States, the Commonwealth of Puerto Rico, or 188
any state or instrumentality of any of them, or of the District of 189
Columbia or of any commission, board, or other instrumentality of 190
one or more of them, provided there is a specific pledge of 191
revenues, and provided that there is adequate provision for 192
payment of interest prior to completion of construction and that 193
rates, fees, tolls, or charges fixed are, after completion of 194
construction, sufficient to pay all expenses of operation and 195
maintenance and the principal and interest when due. 196

(2) In legally authorized and executed bonds, notes, 197
warrants, and securities which are the direct obligation of or are 198
guaranteed by Canada, or which are the direct obligation of or are 199
guaranteed as to both principal and interest by any province of 200
Canada, or which are the direct obligation of or are guaranteed as 201

to both principal and interest by any municipality of Canada 202
having a population of fifty thousand or more by the latest 203
official census, and which are not in default as to principal or 204
interest; 205

(3) In bonds or other evidence of indebtedness, not in 206
default as to principal or interest, which are valid obligations 207
issued, assumed, or guaranteed by the United States, by any state 208
thereof, the Commonwealth of Puerto Rico, or by the District of 209
Columbia, if by statutory or other legal requirements such 210
obligations are payable, as to both principal and interest, from 211
selective taxes levied by such governmental unit. 212

(J)(1) In mortgage bonds which are the direct obligation of a 213
railroad, and which are the first lien on a substantial portion of 214
its property, situated wholly in the United States or partly in 215
the United States and partly in Canada, the average net yearly 216
earnings of which, after deducting proper charges for maintenance 217
of way and equipment, for the five fiscal years preceding such 218
investments, have been at least one and one-half times the average 219
yearly interest for the same period on its mortgages, bonds, and 220
funded debts, and in the junior mortgage bond issues of such 221
railroad corporations of the same character and under the same 222
conditions where the average net yearly earnings for the five 223
fiscal years preceding such investment, after deducting proper 224
charges for maintenance of way and equipment, have been at least 225
three times the average yearly interest charges on such issues and 226
all prior liens; or in the mortgage bonds of any incorporated 227
railroad company which have been assumed or guaranteed, both as to 228
principal and interest, by any incorporated railroad company whose 229
bonds constitute a legal investment under division (J)(1) of this 230
section. In applying the earnings test to any issuing, assuming, 231
or guaranteeing company, whether or not in legal existence during 232
the whole of such five years next preceding the date of investment 233

by such insurer, which has at any time during such five-year 234
period acquired the assets of any other company by purchase, 235
merger, consolidation, or otherwise, substantially as an entirety, 236
or has been reorganized pursuant to the bankruptcy law, the 237
earnings of such other predecessor or constituent companies, or of 238
the company so reorganized, available for interest for such 239
portion of such period that has preceded such acquisition, or such 240
reorganization, may be included in the earnings of such issuing, 241
assuming, or guaranteeing company for such portion of such period 242
as is determined in accordance with adjusted or pro forma 243
consolidated earnings statements covering such portion of such 244
period. In such cases the requirements as to earnings shall be 245
based upon the mortgages, bonds, and funded debts as they exist 246
immediately after such acquisitions or such reorganizations. 247

(2) In mortgage bonds or other interest-bearing obligations 248
of terminal companies organized under the laws of the United 249
States or any state thereof, provided such bonds or obligations 250
have been assumed or guaranteed jointly or severally by two or 251
more railroad corporations whose bonds constitute legal 252
investments under division (J)(1) of this section; 253

(3) In loans to veterans guaranteed in whole or in part by 254
the United States pursuant to Title III of the "Servicemen's 255
Readjustment Act of 1944," 58 Stat. 284, 38 U.S.C.A. 693, as 256
amended, provided such guaranteed loans are liens upon real 257
estate; 258

(4) In mortgage bonds which are the direct obligation of and 259
first lien upon the property of a corporation engaged directly and 260
primarily in the production and sale of, or in the purchase and 261
sale of electricity or gas, or in the operation of telephone or 262
telegraph systems or waterworks, or in some combination of them, 263
and situated wholly in the United States, or the Commonwealth of 264
Puerto Rico, or partly in the United States and partly in Canada, 265

the average net yearly earnings of which, after deducting proper 266
charges for replacements, depreciation, and obsolescence, for the 267
five fiscal years preceding such investment, have been at least 268
one and one-half times the average yearly interest for the same 269
period on its mortgages, bonds, and funded debts; 270

(5) Any such corporation, or any of its predecessors, 271
constituent, or successor corporations, must have been in business 272
not less than ten years prior to the date of the purchase of such 273
bonds, and must not have defaulted on the interest or principal of 274
any of its bonds or funded debts outstanding during the five years 275
immediately preceding the date of purchase, provided that division 276
(J)(5) of this section does not preclude investments in mortgage 277
bonds of railroads reorganized through purchase of assets, merger, 278
consolidation, bankruptcy proceedings, or otherwise if such bonds 279
are eligible for investment under division (J)(1) of this section; 280

(6) No investment shall be made under division (J)(1), (2), 281
(4), or (5) of this section if such railroad or other utility 282
corporation and its business, and its issue of bonds, funded 283
debts, and stocks are not under the supervision and control of an 284
authorized state or federal official or commission, provided that 285
division (J)(6) of this section does not apply to the mortgage 286
bonds or other interest-bearing obligations of companies engaged 287
in the operation of telephone or telegraph systems. 288

(K)(1) In bonds or notes secured by mortgages or deeds of 289
trust which are a first lien upon unencumbered fee simple real 290
estate in any state, the Commonwealth of Puerto Rico, the District 291
of Columbia, or Canada, provided the amount loaned does not exceed 292
eighty per cent of the actual market value of such property. 293

The actual market value of any such property shall be shown 294
by a valuation and appraisalment in writing by a qualified land 295
appraiser. 296

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 329
shall be insured against fire for the benefit of the mortgagee in 330
an amount not less than the difference between seventy-five per 331
cent of the value of such land, exclusive of buildings, and the 332
amount loaned; the policies for such amount shall be payable to 333
and held by the mortgagee or a trustee named in the lease who 334
shall be required by the terms of said lease to use and apply the 335
proceeds of such insurance for repairing, restoring, or rebuilding 336
such buildings; 337

(4) The following shall not be considered as prior liens or 338
encumbrances in the construction and application of this section: 339
leasehold estates of any duration, rights-of-way, servitudes, 340
joint driveways, easements, party wall agreements, current taxes 341
and assessments not delinquent, and restrictions as to building, 342
use, and occupancy. 343

(5) This section does not prohibit a domestic life insurance 344
company from renewing or extending a loan for the original or a 345
lesser amount nor does it prohibit a company from accepting as 346
part payment for real estate sold by it a mortgage on the real 347
estate for a greater percentage of the purchase price of the real 348
estate than is otherwise permitted by this section. 349

(L) In bonds, notes, or other evidences of indebtedness of 350
corporations, trusts, partnerships, or similar business entities 351
organized under the laws of the United States, or any state 352
thereof, the Commonwealth of Puerto Rico, the District of 353
Columbia, or Canada or any province of Canada, secured by 354
assignment of lease or leases or the rentals payable under such 355
leases, of real or personal property or both to (1) the United 356
States or any instrumentality thereof, or any state of the United 357
States, the Commonwealth of Puerto Rico, or the District of 358
Columbia, or any county, city, town, school, or water district, 359
authority, or other political subdivision in any such government, 360

or Canada, any province of Canada, or any municipal corporation of 361
Canada that has a population of fifty thousand or more by the 362
latest official census; or (2) one or more corporations, trusts, 363
partnerships, or similar business entities organized under the 364
laws of the United States, any state thereof, the Commonwealth of 365
Puerto Rico, the District of Columbia, or Canada or any province 366
of Canada, provided that (a) the fixed rentals assigned shall be 367
sufficient to repay the indebtedness within the unexpired term of 368
the lease, exclusive of the term which may be provided by an 369
enforceable option of renewal; (b) such lessee has not defaulted 370
in payment of interest or principal on any of its bonds, notes, 371
debentures, or other evidences of indebtedness during the five 372
years immediately preceding the date of the investment, and 373
provided the average net earnings available for fixed charges of 374
such lessee under division (L)(2) of this section for not less 375
than five fiscal years preceding such investment have been at 376
least one and one-half times average fixed charges for that period 377
and during either of the last two years of such period, the net 378
earnings available for fixed charges shall have been not less than 379
one and one-half times fixed charges for such year, except that 380
railroad companies and utility companies may qualify as lessees 381
herein by application of the earnings test provided for railroads 382
under division (J)(1) of this section and for utilities under 383
division (J)(4) of this section; and (c) a first lien on the 384
interest of the lessor in the unencumbered property so leased 385
shall be obtained as additional security for the indebtedness; 386

(M) In ground rents, land trust certificates, or fee 387
ownership certificates representing or evidencing beneficial 388
ownership of or interest in improved real estate under lease for 389
not less than twenty-five years from the date of such lease, in 390
which it must be provided that the lessee shall pay all taxes and 391
assessments levied on or assessed against said real estate, shall 392
maintain the improvements on the real estate in good repair, and 393

shall provide and maintain fire insurance in an amount equal to 394
the insurable value of the building on the real estate; provided: 395

(1) The value of the land and improvements shall be evidenced 396
by an appraisalment made under oath by a disinterested appraiser 397
resident in and the owner of real estate in the city in which the 398
property is situated, and such appraisalment shall not be less than 399
one and sixty-seven hundredths times the amount of such land trust 400
certificates, which amount shall be not less than twenty times the 401
net annual rental distributable to holders of outstanding 402
certificates; 403

(2) Such beneficial interests shall only be in properties on 404
which actual earning records for five years immediately preceding 405
are available; 406

(3) Such declaration of trust or other trust instrument shall 407
provide for a depreciation or other similar fund, in an amount 408
which is not less than nine per cent of the net annual 409
distributable rental, for the benefit of the holders of 410
outstanding certificates. 411

(N)(1) In certificates of deposit or other evidence of 412
indebtedness of a savings and loan association provided the 413
certificates or other evidence of deposit are insured pursuant to 414
the "Financial Institutions Reform, Recovery, and Enforcement Act 415
of 1989," 103 Stat. 183, 12 U.S.C.A. 1811, as amended; 416

(2) In interest-bearing obligations, including savings 417
accounts and time certificates of deposit of a national bank or 418
state bank provided such bank is a member of the federal deposit 419
insurance corporation created pursuant to the "Banking Act of 420
1933," 92 Stat. 624, 12 U.S.C.A. 624, as amended. 421

(O) In obligations issued, assumed, or guaranteed by the 422
international finance corporation or by the international bank for 423
reconstruction and development, the Asian development bank, the 424

inter-American development bank, the African development bank, or 425
other similar development bank in which the president, as 426
authorized by congress and on behalf of the United States, has 427
accepted membership; 428

(P)(1) In the preferred stocks of any company organized under 429
the laws of the United States or of any state thereof engaged 430
directly and primarily in the production and sale of, or in the 431
purchase and sale of electricity or gas, or in the operation of 432
telephone or telegraph systems or water works, or in some 433
combination of them, if the average annual net earnings of such 434
company, for not less than five fiscal years preceding purchase 435
thereof, after deduction of interest on all mortgages, bonds, 436
debentures, and funded debts and after deduction of the proper 437
charges for replacements, depreciation, and obsolescence, have 438
been at least two times the average yearly amount which is 439
required to pay the dividends or distributions on all preferred 440
stocks; and in which the mortgages, bonds, debentures, funded 441
debts, and preferred stocks shall not in the aggregate exceed 442
seventy per cent of the total capitalization of such company, 443
including mortgages, bonds, debentures, funded debts, and 444
preferred and common stocks; 445

(2) In the preferred stocks of any other company organized 446
under the laws of the United States, or of any state thereof if 447
the average annual net earnings of such company for a period of 448
not less than five fiscal years preceding purchase thereof, after 449
deduction of interest on all mortgages, bonds, debentures, and 450
funded debts and after deduction of the proper charges for 451
replacements, depreciation, and obsolescence, have been at least 452
four times the amount which is required to pay the dividends or 453
distributions on all preferred stocks, and in which the mortgages, 454
bonds, debentures, funded debts, and preferred stocks shall not in 455
the aggregate exceed sixty per cent of the total capitalization of 456

such company, including mortgages, bonds, debentures, funded 457
debts, and preferred and common stocks; 458

(3) A domestic life insurance company shall not purchase any 459
preferred stocks when the total market values of such stocks then 460
owned with those purchased exceed in the aggregate of book values 461
and purchase price the capital, surplus, and contingency funds, 462
excluding all reserves required by law, of such company on the 463
thirty-first day of December preceding the date of such purchase, 464
or contemplated purchase, provided that in case of appreciations 465
in values of stocks owned the cost rather than the market values 466
shall be used in arriving at such aggregate; the purpose being to 467
restrict the investments of such company in all preferred stocks 468
to capital, surplus, and contingency funds. 469

(4) In the bonds, notes, debentures, or other evidences of 470
indebtedness of a solvent corporation, trust, partnership, or 471
similar business entity existing under the laws of the United 472
States, of any state thereof, the Commonwealth of Puerto Rico, or 473
Canada or any province of Canada, provided that either: 474

(a) The bonds, notes, debentures, or other evidences of 475
indebtedness of such corporation, trust, partnership, or similar 476
business entity are rated 1 or 2 by the securities valuation 477
office of the national association of insurance commissioners; 478

(b) The corporation, trust, partnership, or similar business 479
entity has not defaulted in payment of interest or principal on 480
any of its bonds, notes, debentures, or other evidences of 481
indebtedness during the five years immediately preceding the date 482
of purchase, and the average annual net earnings of such 483
corporation, trust, partnership, or similar business entity that 484
are available for fixed charges for not less than five fiscal 485
years preceding such purchase have been at least one and one-half 486
times the average fixed charges of such corporation, trust, 487
partnership, or similar business entity for that period and during 488

either of the last two years of such period, the net earnings 489
available for fixed charges shall have been not less than one and 490
one-half times the fixed charges of such corporation, trust, 491
partnership, or similar business entity for such year. 492

(5) In common stocks or shares of any solvent incorporated 493
company organized under the laws of the United States, or of any 494
state, district, or territory thereof, or the Commonwealth of 495
Puerto Rico, provided that a dividend or distribution has been 496
paid by the corporation in the preceding twelve months upon such 497
stock to be purchased, or that such corporation, together with its 498
predecessor corporation or corporations, has been in existence for 499
a period of at least five years. No domestic company shall invest 500
in common stock or shares under divisions (P)(5) and (R) of this 501
section a sum exceeding in the aggregate ten per cent of its 502
admitted assets on the preceding thirty-first day of December. 503

(6) In the stocks ~~or~~, limited liability company membership 504
interests, limited partnership interests, or limited liability 505
partnership interests of insurance, financial, investment, and 506
investment management companies, which investment management 507
companies are registered with the securities and exchange 508
commission under the "Investment Company Act of 1940," 54 Stat. 509
789, 15 80a-1, as amended, or the stocks, limited liability 510
company membership interests, limited partnership interests, or 511
limited liability partnership interests in an entity wholly owned 512
by a domestic company or by a domestic company and its affiliates, 513
that is formed and maintained to acquire or hold specific assets 514
or liabilities for bankruptcy remoteness or limitation of 515
liability purposes, except its own stock, but no domestic life 516
insurance company shall invest in such stocks ~~or~~, limited 517
liability company membership interests, or limited liability 518
partnership interests under division (P)(6) of this section, 519
exclusive of its investments in stocks or limited liability 520

company membership interests of insurance company subsidiaries or 521
subsidiaries engaged exclusively in the ownership of insurance 522
company subsidiaries, a sum exceeding the lesser of fifty per cent 523
of its policyholder surplus or ten per cent of its admitted assets 524
as of the preceding thirty-first day of December unless the 525
approval of the superintendent of insurance is first obtained. 526
Whenever the superintendent has reason to believe that the 527
retention, investment, or acquisition of the stock ~~of~~ limited 528
liability company membership interest, limited partnership 529
interest, or limited liability partnership interest of any such 530
company substantially lessens competition generally in the 531
business of insurance or creates a monopoly therein the 532
superintendent shall proceed under section 3901.13 of the Revised 533
Code to cause such domestic insurance company to divest itself of 534
such stock ~~of~~ limited liability company membership interest, 535
limited partnership interest, or limited liability partnership 536
interest. 537

(7)(a) In bonds, notes, debentures, or other evidences of 538
indebtedness issued, assumed, or guaranteed by a solvent 539
corporation, trust, or partnership formed or existing under the 540
laws of a foreign jurisdiction, provided each such foreign 541
investment is of the same kind and quality as United States 542
investments authorized under this section; or in common or 543
preferred stock ~~of~~ shares, membership interest, or partnership 544
interest of any solvent ~~corporation~~ business entity formed or 545
existing under the laws of a foreign jurisdiction provided each 546
such foreign investment is of the same kind and quality as United 547
States investments authorized under this section; or in bonds or 548
other evidences of indebtedness issued, assumed, or guaranteed by 549
a foreign jurisdiction. 550

An insurer shall not invest in foreign investments under 551
division (P)(7) of this section, including investments denominated 552

in foreign currency, a sum exceeding in the aggregate fifteen per 553
cent of its admitted assets as of the preceding thirty-first day 554
of December. The aggregate amount of investments held by an 555
insurer in a single foreign jurisdiction shall not exceed three 556
per cent of its admitted assets as of the preceding thirty-first 557
day of December. 558

As used in division (P)(7)(a) of this section, "foreign 559
jurisdiction" means a jurisdiction outside the United States, 560
Puerto Rico, or Canada, whose bonds are rated 1 by the securities 561
valuation office of the national association of insurance 562
commissioners. 563

(b) An insurer may acquire investments denominated in foreign 564
currency whether or not they are foreign investments. 565

An insurer shall not invest in investments denominated in 566
foreign currency a sum exceeding in the aggregate ten per cent of 567
its admitted assets as of the preceding thirty-first day of 568
December. The aggregate amount of investments denominated in a 569
single foreign currency held by an insurer shall not exceed three 570
per cent of an insurer's admitted assets as of the preceding 571
thirty-first day of December. 572

(c) As used in division (P)(7) of this section, "foreign 573
currency" means a currency other than that of the United States. 574

(8) An insurer may invest without limitation in investments 575
of government money market funds. As used in division (P)(8) of 576
this section, "government money market fund" means a mutual fund 577
that at all times invests in obligations issued, guaranteed, or 578
insured by the federal government of the United States, or 579
collateralized repurchase agreements comprised of these 580
obligations, and that qualifies for investment without a reserve 581
pursuant to the purposes and procedures of the securities 582
valuation office of the national association of insurance 583

commissioners. 584

(Q) In loans upon the pledge of any securities in which such 585
companies are authorized by this section to invest, provided that 586
any loan upon such a pledge shall not exceed eighty per cent of 587
the cash market value of the collateral at the time of the making 588
of such loan and at the end of each twelve-month period 589
thereafter, and such company, through the collateral pledged to 590
it, shall not exceed the amounts which it may, under this section, 591
invest in one corporation so that, in the stocks and securities 592
which may be owned and those which are pledged to it, the 593
limitations in this section might be indirectly evaded; 594

(R)(1) Any domestic legal reserve life insurance company may 595
loan or invest its funds, to an extent not exceeding in the 596
aggregate five per cent of its total admitted assets, in loans or 597
investments not permitted under this section. Any such company may 598
also invest up to an additional five per cent of its total 599
admitted assets, in loans or investments in small businesses 600
having more than half of their assets or employees in this state 601
and in venture capital firms having an office within this state, 602
provided that, as a condition of a company making an investment in 603
a venture capital firm, the firm must agree to use its best 604
efforts to make investments, in an aggregate amount at least equal 605
to the investment to be made by the company in that venture 606
capital firm, in small businesses having their principal offices 607
within this state and having either more than one-half of their 608
assets within this state or more than one-half of their employees 609
employed within this state. 610

As used in division (R) of this section: 611

(a) "Small businesses" means any corporation, partnership, 612
proprietorship, or other entity that either does not have more 613
than four hundred employees, or would qualify as a small business 614
for the purpose of receiving financial assistance from small 615

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 648
share in the purchase of investments for their individual accounts 649
and for bona fide investment purposes. 650

(2) In the determination of capitalization in this section 651
the value of all bonds, debentures, and funded debts, and 652
nonconvertible or nonparticipating preferred stocks shall be 653
figured at par. Participating or convertible preferred shares 654
shall be figured at par or market on the preceding thirty-first 655
day of December, whichever is higher, and the value of all common 656
shares shall be figured at the market on the preceding 657
thirty-first day of December. 658

(3) As used in this section: 659

(a) "Funded debt" means all interest-bearing obligations 660
maturing in more than one year from their issuance and all 661
guaranteed or assumed interest-bearing obligations or stock. 662
Securities or stock of a corporation pledged to secure other 663
funded debt of the corporation are not included in the funded 664
debt. 665

(b) "Fixed charges" include actual interest incurred in each 666
year on funded and unfunded debt and annual apportionment of debt 667
discount or premium. Where interest is partially or entirely 668
contingent upon earnings, "fixed charges" include contingent 669
interest payments. 670

(c) "Net earnings available for fixed charges" means income 671
after deducting operating and maintenance expenses, taxes other 672
than income taxes, depreciation, and depletion. Extraordinary, 673
nonrecurring items of income or expense shall be excluded. 674

(4) Except as provided in a plan of mutualization adopted 675
pursuant to the provisions of sections 3913.01 to 3913.10 of the 676
Revised Code, no domestic life insurance company may invest in or 677
loan upon its own stock, either directly or indirectly. 678

(5) If the investments of any domestic life insurance company 679
are at the time of the making thereof or on October 13, 1953, 680
otherwise than as authorized in this section, such investments 681
shall not be admitted or accepted as authorized investments for 682
such company. 683

(6) Any earnings test provided for in this section shall be 684
deemed to have been met if the requirements of such earnings test 685
are met by any company which assumes or guarantees the investment 686
or which assumes or guarantees the performance of any lease which 687
is the security for the investment. In applying any such earnings 688
test, the operations of a company's predecessor companies, if any, 689
for the stipulated period shall be included. 690

(7) No domestic life insurance company shall at any time have 691
invested in or loaned upon the security of the obligations, 692
property, or securities of a particular corporation, trust, 693
partnership, or similar business entity a sum exceeding the 694
greater of two per cent of its admitted assets as of the preceding 695
thirty-first day of December or twenty-five per cent of that 696
portion of its capital and surplus, or its surplus in the case of 697
a mutual company, that exceeds the minimum required capital and 698
surplus under section 3907.05 of the Revised Code unless the 699
approval of the superintendent of insurance is first obtained. The 700
restrictions of division (S)(7) of this section do not apply to 701
divisions (C), (F), (G), (H), (P)(6), and (R) of this section or 702
to any valid obligation issued, assumed, or guaranteed by the 703
United States, or any state thereof, the Commonwealth of Puerto 704
Rico, the District of Columbia, or Canada or any province of 705
Canada. For purposes of division (S)(7) of this section, such 706
company may, at its option, consider either the lessor or the 707
lessee under division (L) of this section to be the person to whom 708
any such investment or loan is made. 709

(8) This section does not affect the propriety or legality of 710

an investment made by a domestic life insurance company which was 711
in accordance with the laws in force at the time of the making of 712
the investment. 713

Sec. 3921.10. A domestic fraternal benefit society organized 714
on or after January 1, 1997, shall be formed as follows: 715

(A) Seven or more citizens of the United States, a majority 716
of whom are residents of this state, who desire to form a 717
fraternal benefit society, may make, sign, and acknowledge before 718
some officer competent to take acknowledgement of deeds, articles 719
of incorporation stating all of the following: 720

(1) The proposed corporate name of the society, which name 721
shall not so closely resemble the name of any society or insurance 722
company as to be misleading or confusing; 723

(2) The purposes for which it is being formed and the mode in 724
which its corporate powers are to be exercised. Such purposes 725
shall not include more liberal powers than are granted by this 726
chapter. 727

(3) The names and residences of the incorporators and the 728
names, residences, and official titles of all the officers, 729
trustees, directors, or other persons who are to have and exercise 730
the general control of the management of the affairs and funds of 731
the society for the first year or until the ensuing election at 732
which all such officers shall be elected by the supreme governing 733
body, which election shall be held not later than one year from 734
the date of the issuance of the permanent certificate of 735
authority. 736

(B) The articles of incorporation, duly certified copies of 737
the society's bylaws and rules, copies of all proposed forms of 738
certificates, applications for certificates, and circulars to be 739
issued by the society, and a bond conditioned upon the return to 740

applicants of the advanced payments if the organization is not 741
completed within one year, shall be filed with the superintendent 742
of insurance, who may require any other information the 743
superintendent considers necessary. The bond with sureties 744
approved by the superintendent shall be in such amount, not less 745
than three hundred thousand dollars nor more than one million five 746
hundred thousand dollars, as required by the superintendent. All 747
documents filed shall be in the English language. If the purposes 748
of the society conform to the requirements of this chapter and all 749
provisions of the laws of this state have been complied with, the 750
superintendent shall so certify, retain and file the articles of 751
incorporation, and furnish the incorporators a preliminary 752
certificate of authority authorizing the society to solicit 753
members as provided in this section. 754

(C) No preliminary certificate of authority granted under 755
this section shall be valid after one year from its date or after 756
such additional period, not exceeding one year, as may be 757
authorized by the superintendent upon cause shown, unless the five 758
hundred applicants required in division (D) of this section have 759
been secured and the organization has been completed as provided 760
in this section. The articles of incorporation and all other 761
proceedings thereunder shall be void one year after the date of 762
the preliminary certificate of authority, or at the expiration of 763
the extended period, unless the society has completed its 764
organization and has received a certificate of authority to do 765
business as provided in division (E) of this section. 766

(D) Upon receipt of a preliminary certificate of authority 767
from the superintendent, the society may solicit members for the 768
purpose of completing its organization, shall collect from each 769
applicant the amount of not less than one regular monthly premium 770
in accordance with its table of rates, and shall issue to each 771
applicant a receipt for the amount so collected. No society shall 772

incur any liability other than for the return of such advance 773
premium, nor issue any certificate, nor pay, allow, or offer, or 774
promise to pay or allow, any benefit to any person until all of 775
the following apply: 776

(1) Actual bona fide applications for benefits have been 777
secured aggregating at least two million five hundred thousand 778
dollars on not less than five hundred applicants, and any 779
necessary evidence of insurability has been furnished to and 780
approved by the society. 781

(2) At least ten subordinate lodges have been established 782
into which the five hundred applicants have been admitted. 783

(3) There has been submitted to the superintendent, under 784
oath of the president or secretary, or corresponding officer of 785
the society, a list of such applicants, giving their names, 786
addresses, date each was admitted, name and number of the 787
subordinate lodge of which each applicant is a member, amount of 788
benefits to be granted, and premiums for the benefits. 789

(4) It has been shown to the superintendent, by sworn 790
statement of the treasurer, or corresponding officer of the 791
society, that at least five hundred applicants have each paid in 792
cash at least one regular monthly premium as provided in this 793
section, which premiums in the aggregate amount to at least one 794
hundred fifty thousand dollars, all of which is credited to the 795
fund or funds from which benefits are to be paid and no part of 796
which may be used for expenses. These advance premiums shall be 797
held in trust during the period of organization and if the society 798
has not qualified for a certificate of authority within one year, 799
as provided in this section, the premiums shall be returned to the 800
applicants. 801

(E) The superintendent may make such examination and require 802
such further information as the superintendent considers 803

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 835
(A)(2) of section 3921.16 of the Revised Code in this state in a 836
benefit amount of greater than ten thousand dollars shall have and 837
maintain a surplus of two million five hundred thousand dollars 838
for all lines written. 839

(2) On and after January 1, 2016, a fraternal benefit society 840
that provides the contractual benefits listed in division (A)(2) 841
of section 3921.16 of the Revised Code in this state in a benefit 842
amount of ten thousand dollars or less shall have and maintain a 843
surplus of five hundred thousand dollars. 844

(C)(1) On and after January 1, 2016, a fraternal benefit 845
society that provides the contractual benefits listed in division 846
(A)(3) of section 3921.16 of the Revised Code in this state in a 847
benefit amount of greater than ten thousand dollars shall have and 848
maintain a surplus in the aggregate of two million five hundred 849
thousand dollars for all lines written. 850

(2) On and after January 1, 2016, a fraternal benefit society 851
that provides the contractual benefits listed in division (A)(3) 852
of section 3921.16 of the Revised Code in this state in a benefit 853
amount of ten thousand dollars or less shall have and maintain a 854
surplus of five hundred thousand dollars. 855

(D) On and after January 1, 2016, a fraternal benefit society 856
that provides the contractual benefits listed in division (A)(4) 857
of section 3921.16 of the Revised Code in this state shall have 858
and maintain a surplus of two million five hundred thousand 859
dollars for all lines written. 860

(E) On and after January 1, 2016, a fraternal benefit society 861
that provides the contractual benefits listed in division (A)(5) 862
of section 3921.16 of the Revised Code in this state shall have 863
and maintain a surplus of two million five hundred thousand 864
dollars for all lines written. 865

(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. 866
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(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. 870
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(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. 875
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Sec. 3921.13. (A) A domestic fraternal benefit society may, 879
by a reinsurance agreement, cede any individual risk or risks in 880
whole or in part to an insurer, other than another fraternal 881
benefit society, having the power to make such reinsurance and 882
authorized to do business in this state, or if not so authorized, 883
one which is approved by the superintendent of insurance; however, 884
no society may reinsure substantially all of its insurance in 885
force without the written permission of the superintendent. It may 886
take credit for the reserves on the ceded risks to the extent 887
reinsured, but no credit shall be allowed as an admitted asset or 888
as a deduction from liability, to a ceding society for reinsurance 889
made, ceded, renewed, or otherwise becoming effective after 890
January 1, 1997, unless the reinsurance is payable by the assuming 891
insurer on the basis of the liability of the ceding society under 892
the contract or contracts reinsured without diminution because of 893
the insolvency of the ceding society. 894

(B) Notwithstanding division (A) of this section, a society 895
may reinsure the risks of another society in a consolidation or 896

merger approved by the superintendent under section 3921.14 of the Revised Code. 897
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(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. 899
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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. 905
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All statements made on the application are representations and not warranties. Any waiver of this provision is void. 917
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(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. 919
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(C) Any person upon whose life a benefit contract is issued 928
prior to attaining the age of majority shall be bound by the terms 929
of the application and certificate and by all of the laws and 930
rules of the society to the same extent as though the age of 931
majority had been attained at the time of application. 932

(D) A society shall provide in its laws that if its reserves 933
as to all or any class of certificates become impaired its board 934
of directors or corresponding body may require that there shall be 935
paid by the owner to the society the amount of the owner's 936
equitable proportion of such deficiency as ascertained by its 937
board, and that if the payment is not made, either of the 938
following applies: 939

(1) It shall stand as an indebtedness against the certificate 940
and draw interest not to exceed the rate specified for certificate 941
loans under the certificates; 942

(2) In lieu of or in combination with division (D)(1) of this 943
section, the owner may accept a proportionate reduction in 944
benefits under the certificate. 945

The society may specify the manner of the election and which 946
alternative is to be presumed if no election is made. 947

(E) At least thirty days prior to imposing any indebtedness 948
upon any owner as provided in division (D) of this section, the 949
board of directors or corresponding body shall notify the 950
superintendent of insurance in writing of the board's intent to 951
require the payment and a statement of the reason that request is 952
necessary. The notice shall be confidential and not a public 953
record under section 149.43 of the Revised Code. 954

(F)(1) Certificates that are delivered or issued for delivery 955
in this state on or after January 1, 1997, but prior to January 1, 956
1998, shall comply with the requirements that would have applied 957
under the laws in effect on December 31, 1996. 958

(2) No certificate shall be delivered or issued for delivery 959
in this state on or after January 1, 1998, unless a copy of the 960
form is filed with and approved by the superintendent of insurance 961
in accordance with the provisions of law applicable to like 962
policies issued by life or sickness and accident insurers in this 963
state. 964

(3) Each life, sickness and accident, or disability insurance 965
certificate, and each annuity certificate, that is delivered or 966
issued for delivery in this state on or after January 1, 1998, 967
shall comply with the standard contract provision requirements 968
applicable to like policies issued by life or sickness and 969
accident insurers in this state, if those requirements are not 970
inconsistent with this chapter. However, a society may provide in 971
its certificates for a grace period of one full month for payment 972
of premiums. A certificate shall also contain a provision that 973
states the amount of premiums that is payable under the 974
certificate and that sets forth the substance of any sections of 975
the society's laws or rules in force at the time of issuance of 976
the certificate which, if violated, will result in the termination 977
or reduction of benefits payable under the certificate. If the 978
laws of the society provide for the expulsion or suspension of a 979
member, the certificate shall also contain a provision stating 980
that any member expelled or suspended, except a member expelled or 981
suspended because of nonpayment of a premium, may maintain, other 982
than during the contestable period for material misrepresentation 983
in the application for membership or insurance, the certificate in 984
force by continuing payment of the required premium. 985

~~(F)~~(G) Benefit contracts issued on the lives of persons under 986
the society's minimum age for adult membership may provide for 987
transfer of control of ownership to the insured at an age 988
specified in the certificate. A society may require approval of an 989
application for membership in order to effect this transfer, and 990

may provide in all other respects for the regulation, government, 991
and control of such certificates and all rights, obligations, and 992
liabilities incident to and connected with such certificates. 993
Ownership rights prior to such a transfer shall be specified in 994
the certificate. 995

~~(G)~~(H) A society may specify the terms and conditions on 996
which benefit contracts may be assigned. 997

~~(H)~~(I) A copy of any of the documents described in this 998
section, if certified by the secretary or corresponding officer of 999
the society, is prima facie evidence of the terms and conditions 1000
of the documents. 1001

Sec. 3921.191. (A) A fraternal benefit society shall provide 1002
an applicant for contractual benefits a disclosure statement at 1003
the time of sale substantially as follows: 1004

"..... (Name of the fraternal benefit society) IS 1005
LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A 1006
(not-for-profit, tax-exempt, self-governing, or membership 1007
organization), FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE 1008
OHIO GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT 1009
SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE 1010
INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL 1011
BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS 1012
AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A 1013
PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED 1014
IN THE CERTIFICATE ISSUED BY THE SOCIETY." 1015

(B) The statement must be signed by the applicant and 1016
maintained in the certificate or contract file by the fraternal 1017
benefit society. The statement may be part of the society's 1018
membership application or certificate or policy application. 1019

(C) This section is applicable only to new business written 1020

by a fraternal benefit society after the effective date of this 1021
section. 1022

Sec. 3921.22. (A) A fraternal benefit society shall hold, 1023
invest, and disburse all assets for the use and benefit of the 1024
society. No member or beneficiary shall have or acquire individual 1025
rights to the assets, or be entitled to any apportionment on the 1026
surrender of any part of the assets, except as provided in the 1027
benefit contract. 1028

(B) A society may create, maintain, invest, disburse, and 1029
apply any special fund or funds necessary to carry out any purpose 1030
permitted by the laws of the society. No society shall, directly 1031
or indirectly, pay or use, or offer, consent, or agree to pay or 1032
use, any of its funds, money, or property for or in aid of any 1033
political party, campaign committee, political action committee, 1034
continuing association, or any other political organization. 1035

(C) A society may, pursuant to resolution of its supreme 1036
governing body, establish and operate one or more separate 1037
accounts and issue contracts on a variable basis, subject to the 1038
provisions of law regulating life insurers that establish such 1039
accounts and issue such contracts including those described in 1040
section 3911.011 of the Revised Code. To the extent the society 1041
considers it necessary in order to comply with any applicable 1042
federal or state law, or any rule issued under that law, the 1043
society may do any of the following: 1044

(1) Adopt special procedures for the conduct of the business 1045
and affairs of a separate account; 1046

(2) For persons having beneficial interests in the account, 1047
provide special voting and other rights, including special rights 1048
and procedures relating to investment policy, investment advisory 1049
services, selection of certified public accountants, and selection 1050
of a committee to manage the business and affairs of the account; 1051

(3) Issue contracts on a variable basis to which divisions 1052
(B) and (D) of section 3921.19 of the Revised Code do not apply. 1053

Sec. 3921.28. (A)(1) Each domestic fraternal benefit society 1054
and each applicant for a certificate of incorporation as a 1055
domestic fraternal benefit society shall be subject to examination 1056
by the superintendent of insurance in accordance with section 1057
3901.07 of the Revised Code. Section 3901.07 of the Revised Code 1058
shall govern every aspect of the examination, including the 1059
circumstances under and frequency with which it is conducted, and 1060
the authority of the superintendent and any examiner or other 1061
person appointed by the superintendent. 1062

(2)(a) A domestic fraternal benefit society shall be liable 1063
for the payment of any additional expense of an examination 1064
resulting from unreasonable delays by the society in fulfilling a 1065
request for documents or information by the examiner conducting 1066
the examination. A delay is deemed unreasonable if the examiner 1067
has made two separate unfulfilled requests for the same documents 1068
or information. A request for records or information from an 1069
examiner shall allow the fraternal benefit society a minimum of 1070
ten business days to fulfill the request. 1071

(b) In the event of an unreasonable delay, the examiner shall 1072
notify the superintendent, who shall set a hearing, under Chapter 1073
119. of the Revised Code, to determine if there has been an 1074
unreasonable delay because of the fraternal benefit society's 1075
response to a request for documents or information and to 1076
calculate the additional expense incurred by the superintendent as 1077
a result of the unreasonable delay. 1078

(3) A summary of the examination of the superintendent and 1079
any recommendations or statements of the superintendent that 1080
accompany the report, shall be read at the first meeting of the 1081
board of directors or corresponding body of the society following 1082

the receipt thereof, and if directed so to do by the 1083
superintendent, shall also be read at the first meeting of the 1084
supreme legislative or governing body of the society following the 1085
receipt thereof. A copy of the report, recommendations, and 1086
statements of the superintendent shall be furnished by the society 1087
to each member of the board of directors or other governing body. 1088

(B) Each foreign or alien fraternal benefit society 1089
transacting or applying for admission to transact business in this 1090
state shall be subject to examination by the superintendent in 1091
accordance with section 3901.07 of the Revised Code. Section 1092
3901.07 of the Revised Code shall govern every aspect of the 1093
examination, including the circumstances under and frequency with 1094
which it is conducted, the authority of the superintendent and any 1095
examiner or other person appointed by the superintendent, the 1096
liability for the assessment of expenses incurred in conducting 1097
the examination, and the remittance of the assessment to the 1098
superintendent's examination fund. 1099

Sec. 3921.29. No foreign or alien fraternal benefit society 1100
shall transact business in this state without a license issued by 1101
the superintendent of insurance. Any such society may be licensed 1102
to transact business in this state upon filing all of the 1103
following with the superintendent: 1104

(A) A duly certified copy of its articles of incorporation; 1105

(B) A copy of its bylaws certified by its secretary or 1106
corresponding officer; 1107

(C) A ~~power of attorney to the superintendent~~ written 1108
appointment of an agent as prescribed in section 3921.35 of the 1109
Revised Code; 1110

(D) A statement of its business made under oath of its 1111
president and secretary or corresponding officers in a form 1112

prescribed by the superintendent and duly verified by an 1113
examination made by the supervising insurance official of its 1114
state of domicile or of any other state, district, territory, 1115
province, or country, which examination is satisfactory to the 1116
superintendent; 1117

(E) Certification from the proper official of its state, 1118
district, territory, province, or country of domicile that the 1119
society is legally incorporated and licensed to transact business 1120
in that state, district, territory, province, or country; 1121

(F) Copies of its certificate forms; 1122

(G) A description of its investments that shows that its 1123
assets are invested in accordance with this chapter; 1124

(H) Any other information the superintendent considers 1125
necessary. 1126

Sec. 3921.30. ~~(A)~~ If the superintendent of insurance finds, 1127
upon investigation, that a domestic fraternal benefit society has 1128
exceeded its powers, has failed to comply with any provision of 1129
this chapter, is not fulfilling its contracts in good faith, has a 1130
membership of less than four hundred after an existence of one 1131
year or more, or is conducting business fraudulently or in a 1132
manner hazardous to its members, creditors, the public, or the 1133
business, the superintendent shall issue a written notice to the 1134
society that sets forth the deficiency and the reasons for the 1135
superintendent's dissatisfaction, and that requires the society to 1136
correct the deficiency within thirty days after receipt of the 1137
notice. If the society fails to correct the deficiency within that 1138
thirty-day period, the superintendent shall ~~notify the society of~~ 1139
~~its failure to correct the deficiency and shall require the~~ 1140
~~society to show cause on a date named why it should not be~~ 1141
~~enjoined from carrying on any business until the violation~~ 1142
~~complained of has been corrected, or why an action in quo warranto~~ 1143

~~should not be commenced against the society.~~ 1144

~~If on that date the society does not present good and 1145
sufficient reasons why it should not be enjoined or why such 1146
action should not be commenced, the superintendent may present the 1147
facts relating thereto to the attorney general. If the attorney 1148
general determines that the circumstances warrant, the attorney 1149
general shall commence an action to enjoin the society from 1150
transacting business or in quo warranto. 1151~~

~~The court shall thereupon notify the officers of the society 1152
of a hearing. If after a full hearing it appears that the society 1153
should be enjoined or liquidated or a receiver appointed, the 1154
court shall enter the necessary order. 1155~~

~~(B) A society enjoined pursuant to division (A) of this 1156
section shall not have the authority to do business until all of 1157
the following occur: 1158~~

~~(1) The superintendent finds that the violation complained of 1159
has been corrected. 1160~~

~~(2) The costs of the action have been paid by the society if 1161
the court finds that the society was in default as charged. 1162~~

~~(3) The court has dissolved its injunction. 1163~~

~~(4) The superintendent has reinstated the certificate of 1164
authority. 1165~~

~~(C) If the court orders the society liquidated, the society 1166
shall be enjoined from carrying on any further business, whereupon 1167
the receiver of the society shall proceed at once to take 1168
possession of the books, papers, money, and other assets of the 1169
society and, under the direction of the court, shall close the 1170
affairs of the society and distribute its funds to those entitled 1171
to them. 1172~~

~~(D) No action under this section shall be recognized in any 1173~~

~~court of this state unless brought by the attorney general upon 1174
request of the superintendent. Whenever a receiver is to be 1175
appointed for a domestic society, the court shall appoint the 1176
superintendent as the receiver. 1177~~

~~(E) The provisions of this section relating to a hearing by 1178
the superintendent, action by the attorney general at the request 1179
of the superintendent, hearing by the court, injunction, and 1180
receivership shall apply to any society that voluntarily 1181
determines to discontinue business. 1182~~

~~(F) Nothing in this section shall be construed as preventing 1183
the lodges and members of a society from commencing a civil action 1184
against a society for the enforcement of a contract provision or 1185
for the resolution of a dispute concerning an interpretation of 1186
the society's laws, which action is not based on the 1187
superintendent's exercise of authority under this section. A 1188
society shall not prohibit a lodge or member from commencing such 1189
commence an action against ~~it~~ the society under sections 3903.01 1190
to 3903.59 of the Revised Code. 1191~~

Sec. 3921.31. ~~(A)~~ If the superintendent of insurance finds, 1192
upon investigation, that a foreign or alien fraternal benefit 1193
society transacting or applying to transact business in this state 1194
has exceeded its powers, has failed to comply with any provision 1195
of this chapter, is not fulfilling its contracts in good faith, or 1196
is conducting its business fraudulently or in a manner hazardous 1197
to its members or creditors or the public, the superintendent 1198
shall issue a written notice to the society that sets forth the 1199
deficiency and the reasons for the superintendent's 1200
dissatisfaction, and that requires the society to correct the 1201
deficiency within thirty days after receipt of the notice. If the 1202
society fails to correct the deficiency within that thirty-day 1203
period, the superintendent shall ~~notify the society of its failure~~ 1204

~~to correct the deficiency and shall require the society to show~~ 1205
~~cause on a date named why its license should not be suspended,~~ 1206
~~revoked, or refused.~~ 1207

~~If on that date the society does not present good and~~ 1208
~~sufficient reason why its authority to do business in this state~~ 1209
~~should not be suspended, revoked, or refused, the superintendent~~ 1210
~~may suspend or refuse the license of the society to do business in~~ 1211
~~this state until satisfactory evidence is furnished to the~~ 1212
~~superintendent that the suspension or refusal should be withdrawn,~~ 1213
~~or the superintendent may revoke the authority of the society to~~ 1214
~~do business in this state.~~ 1215

~~(B) Nothing in this section shall be construed as preventing~~ 1216
~~any foreign or alien society from continuing in good faith all~~ 1217
~~contracts made in this state during the time the society was~~ 1218
~~legally authorized to transact business in this state commence an~~ 1219
~~action against the society under section 3903.71 of the Revised~~ 1220
~~Code.~~ 1221

Sec. 3921.33. (A) Agents of fraternal benefit societies shall 1222
be licensed in the manner provided for agents of insurance 1223
companies in Chapter 3905. of the Revised Code, and shall be 1224
required to complete continuing education as set forth in section 1225
3905.481 of the Revised Code starting with the twenty-four-month 1226
period commencing on the first day of January of 1999. However, no 1227
written or other examination shall be required of any person whose 1228
application for the original issuance of a license to represent a 1229
fraternal benefit society as its agent was filed with the 1230
superintendent of insurance prior to January 1, 1997. 1231

(B) The following persons shall not be required to be 1232
licensed in accordance with division (A) of this section: 1233

(1) Any regularly salaried officer, employee, or member of a 1234
licensed society who devotes substantially all of the person's 1235

services to activities other than the solicitation of fraternal 1236
insurance contracts from the public, and who receives for the 1237
solicitation of any such contracts no commission or other 1238
compensation directly dependent upon the amount of business 1239
obtained. 1240

The officers, employees, and members described in division 1241
(B)(1) of this section also are not subject to examination by the 1242
superintendent under Chapter 3905. of the Revised Code. 1243

(2) Any agent or representative of a society who devotes, or 1244
intends to devote, less than fifty per cent of the person's time 1245
to the solicitation and procurement of insurance contracts for the 1246
society. For purposes of division (B)(2) of this section, any 1247
person who, in the preceding calendar year, has received a 1248
commission or other compensation for soliciting and procuring any 1249
of the following contracts on behalf of an individual society is 1250
presumed to have devoted, or to have intended to devote, fifty per 1251
cent of the person's time to the solicitation and procurement of 1252
insurance contracts: 1253

(a) Life insurance contracts that, in the aggregate, exceeded 1254
two hundred thousand dollars of coverage for all lives insured for 1255
the preceding calendar year; 1256

(b) A permanent life insurance contract offering more than 1257
ten thousand dollars of coverage on an individual life; 1258

(c) A term life insurance contract offering more than fifty 1259
thousand dollars of coverage on an individual life; 1260

(d) Any insurance contracts other than life that the society 1261
may write and that insure the individual lives of more than 1262
twenty-five individuals; 1263

(e) Any contract issued on a variable basis, as authorized by 1264
division (C) of section 3921.22 of the Revised Code. 1265

(C) Notwithstanding division (B) of this section, any person 1266
selling an annuity contract under the authority of division (A)(3) 1267
of section 3921.16 of the Revised Code shall be licensed pursuant 1268
to Chapter 3905. of the Revised Code. 1269

Sec. 3921.35. (A) Any fraternal benefit society authorized to 1270
transact business in this state shall have and maintain an agent 1271
upon whom may be served any process, notice, or demand required or 1272
permitted by law to be served upon a society. 1273

The agent required under this section may be a natural person 1274
residing in this state or a corporation holding a license under 1275
the laws of this state that is authorized by its articles of 1276
incorporation to act as an agent and that maintains a business 1277
address in this state. A statutory agent is not required to be a 1278
licensed insurance agent. 1279

(B) The written appointment of an agent shall be in the form 1280
the superintendent of insurance prescribes and may include a 1281
consent to service of process. 1282

The appointment shall set forth the name and complete address 1283
of the agent. The agent shall reside or maintain a business 1284
address within this state. 1285

(C) The superintendent shall keep a record of the fraternal 1286
benefit societies transacting business in this state and the name 1287
and address of their respective agents. 1288

(D)(1) If any agent dies, moves out of the state, or resigns, 1289
the society immediately shall appoint another agent and file with 1290
the superintendent a written appointment as described in division 1291
(B) of this section. 1292

(2) If an agent changes the agent's address, the society or 1293
agent immediately shall notify the superintendent of the change, 1294
and shall set forth the agent's new address, on a form prescribed 1295

by the superintendent. 1296

(E) An agent may resign by filing with the superintendent a 1297
written notice signed by the agent. The agent shall send a copy of 1298
the notice to the society at the current or last known address of 1299
the society's principal office prior to the date the notice is 1300
filed with the superintendent. 1301

The notice required under this division shall set forth the 1302
society's name, the current or last known address of the society, 1303
the name and address of the agent, the resignation of the agent, 1304
and a statement that a copy of the notice has been sent to the 1305
society and the date the copy was sent. 1306

The agent's authority to represent the fraternal benefit 1307
society shall terminate thirty days after the notice is filed with 1308
the superintendent under this division. 1309

(F) A society may revoke the appointment of an agent by 1310
filing with the superintendent a written appointment of another 1311
agent and a statement that the appointment of the former agent is 1312
revoked. The authority of the agent whose appointment has been 1313
revoked shall terminate thirty days after the notice required 1314
under this division is filed with the superintendent. 1315

(G) Any process, notice, or demand required or permitted by 1316
law to be served upon a society may be served by delivering a copy 1317
of the process, notice, or demand to the agent of record at the 1318
address appearing in the superintendent's records. 1319

If the agent cannot be found, the agent no longer has that 1320
address, or the society has failed to maintain an agent as 1321
required by this section, the party desiring that the process, 1322
notice, or demand be served, or its agent, may file with the 1323
superintendent an affidavit stating that one of the foregoing 1324
conditions exists and stating the most recent address of the 1325
society that the party, after diligent search, has been able to 1326

ascertain. 1327

Upon the filing of the affidavit, service of process, notice, 1328
or demand may be initiated upon the superintendent as the 1329
society's agent by delivering two copies of the process, notice, 1330
or demand to the superintendent. The superintendent shall give 1331
notice to the society at its principal office as shown in the 1332
superintendent's records or at the address set forth in the 1333
affidavit. The superintendent shall give notice by regular mail 1334
with a copy of the process, notice, or demand enclosed. After the 1335
superintendent has mailed the appropriate documents, service upon 1336
the society is deemed complete. 1337

(H) The superintendent shall keep a record of each process, 1338
notice, and demand delivered to the superintendent under division 1339
(G) of this section or any other law of this state that authorizes 1340
service upon the superintendent. 1341

(I) This section does not limit or affect the right to serve 1342
any process, notice, or demand upon a society in any other manner 1343
permitted by law. 1344

(J) A society shall include a fee of five dollars with any 1345
change of agent appointment or change of address. This division 1346
does not apply to an agent appointment filed with an original 1347
application for a certificate of authority. 1348

(K) If a society fails to appoint or maintain an agent or to 1349
notify the superintendent of an agent's change of address, the 1350
superintendent shall provide notice of that failure to the society 1351
by certified mail. If the society does not remedy the society's 1352
failure within thirty days after the date of the mailing of the 1353
notice or within any additional time the superintendent allows, 1354
the superintendent shall fine the society not less than 1355
twenty-five dollars nor more than two hundred dollars per 1356
violation. The superintendent also may charge a society a 1357

fifty-dollar fee for each time the superintendent is required to 1358
give notice to the society in accordance with division (G) of this 1359
section. 1360

(L) The superintendent shall pay all moneys collected by the 1361
superintendent in accordance with this section into the state 1362
treasury to the credit of the department of insurance operating 1363
fund. 1364

Sec. 3922.01. As used in this chapter: 1365

(A) "Adverse benefit determination" means a decision by a 1366
health plan issuer: 1367

(1) To deny, reduce, or terminate a requested health care 1368
service or payment in whole or in part, including all of the 1369
following: 1370

(a) A determination that the health care service does not 1371
meet the health plan issuer's requirements for medical necessity, 1372
appropriateness, health care setting, level of care, or 1373
effectiveness, including experimental or investigational 1374
treatments; 1375

(b) A determination of an individual's eligibility for 1376
individual health insurance coverage, including coverage offered 1377
to individuals through a nonemployer group, to participate in a 1378
plan or health insurance coverage; 1379

(c) A determination that a health care service is not a 1380
covered benefit; 1381

(d) The imposition of an exclusion, including exclusions for 1382
pre-existing conditions, source of injury, network, or any other 1383
limitation on benefits that would otherwise be covered. 1384

(2) Not to issue individual health insurance coverage to an 1385
applicant, including coverage offered to individuals through a 1386
nonemployer group; 1387

(3) To rescind coverage on a health benefit plan.	1388
(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.	1389 1390
(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:	1391 1392 1393 1394
(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;	1395 1396 1397 1398
(2) A person authorized by law to provide substituted consent for a covered individual;	1399 1400
(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.	1401 1402
(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:	1403 1404 1405
(1) Randomized clinical trials;	1406
(2) Cohort studies or case-control studies;	1407
(3) Case series;	1408
(4) Expert opinion.	1409
(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.	1410 1411 1412 1413 1414 1415 1416

(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, 1448
tricare, specified disease, or vision care; coverage issued as a 1449
supplement to liability insurance; insurance arising out of 1450
workers' compensation or similar law; automobile medical payment 1451
insurance; or insurance under which benefits are payable with or 1452
without regard to fault and which is statutorily required to be 1453
contained in any liability insurance policy or equivalent 1454
self-insurance; a medicare supplement policy of insurance, as 1455
defined by the superintendent of insurance by rule, coverage under 1456
a plan through medicare, medicaid, or the federal employees 1457
benefit program; any coverage issued under Chapter 55 of Title 10 1458
of the United States Code and any coverage issued as a supplement 1459
to that coverage. 1460

(M) "Health care professional" means a physician, 1461
psychologist, nurse practitioner, or other health care 1462
practitioner licensed, accredited, or certified to perform health 1463
care services consistent with state law. 1464

(N) "Health care provider" or "provider" means a health care 1465
professional or facility. 1466

(O) "Health care services" means services for the diagnosis, 1467
prevention, treatment, cure, or relief of a health condition, 1468
illness, injury, or disease. 1469

(P) "Health plan issuer" means an entity subject to the 1470
insurance laws and rules of this state, or subject to the 1471
jurisdiction of the superintendent of insurance, that contracts, 1472
or offers to contract to provide, deliver, arrange for, pay for, 1473
or reimburse any of the costs of health care services under a 1474
health benefit plan, including a sickness and accident insurance 1475
company, a health insuring corporation, a fraternal benefit 1476
society, a self-funded multiple employer welfare arrangement, or a 1477
nonfederal, government health plan. "Health plan issuer" includes 1478
a third party administrator licensed under Chapter 3959. of the 1479

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;	1510 1511 1512
(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;	1513 1514 1515
(4) The following standard reference compendia:	1516
(a) The American hospital formulary service drug information;	1517
(b) Drug facts and comparisons;	1518
(c) The American dental association accepted dental therapeutics;	1519 1520
(d) The United States pharmacopoeia drug information.	1521
(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:	1522 1523 1524
(a) The federal agency for health care research and quality;	1525
(b) The national institutes of health;	1526
(c) The national cancer institute;	1527
(d) The national academy of sciences;	1528
(e) The centers for medicare and medicaid services;	1529
(f) The federal food and drug administration;	1530
(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.	1531 1532 1533
(6) Any other medical or scientific evidence that is comparable.	1534 1535
(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.	1536 1537

(U) "Protected health information" means health information 1538
related to the identity of an individual, or information that 1539
could reasonably be used to determine the identity of an 1540
individual. 1541

(V) ~~"Rescission"~~ "Rescind" means ~~a cancellation or~~ 1542
~~discontinuance of coverage that has a retroactive effect to~~ 1543
retroactively cancel or discontinue coverage. ~~"Rescission"~~ 1544
"Rescind" does not include ~~a cancellation or discontinuance of~~ 1545
~~canceling or discontinuing~~ coverage that only has ~~only~~ a 1546
prospective effect or ~~a cancellation or discontinuance of~~ 1547
canceling or discontinuing coverage that is effective 1548
retroactively to the extent it is attributable to a failure to 1549
timely pay required premiums or contributions towards the cost of 1550
coverage. 1551

(W) "Retrospective review" means a review conducted after 1552
services have been provided to a covered person. 1553

(X) "Superintendent" means the superintendent of insurance. 1554

(Y) "Utilization review" has the same meaning as in section 1555
1751.77 of the Revised Code. 1556

(Z) "Utilization review organization" has the same meaning as 1557
in section 1751.77 of the Revised Code. 1558

Sec. 3922.02. (A) A covered person may make a request for an 1559
external review of an adverse benefit determination. 1560

(B) All requests for external review shall be made in 1561
writing, ~~except when making a request for an expedited review~~ 1562
~~under section 3922.09 of the Revised Code~~ including by electronic 1563
means, by the covered person to the health plan issuer within one 1564
hundred eighty days of the date of the final adverse benefit 1565
determination ~~in a form prescribed by the superintendent. Requests~~ 1566
~~for an expedited.~~ However, in the case of an expedited external 1567

~~review under section 3922.09 of the Revised Code, the review may~~ 1568
~~be requested orally or by electronic means. When an oral or~~ 1569
~~electronic request for review is made, written confirmation of the~~ 1570
~~request must be submitted to the health plan issuer no later than~~ 1571
~~five days after the initial request was made.~~ 1572

(C) An adverse benefit determination shall be eligible for 1573
internal appeal or external review, regardless of ~~how small~~ the 1574
cost of the requested health care service related to the adverse 1575
benefit determination ~~is~~. 1576

Sec. 3922.03. (A) All health plan issuers shall implement an 1577
internal appeal process under which a covered person may appeal an 1578
adverse benefit determination. This process must be in compliance 1579
with the "Patient Protection and Affordable Care Act of 2010," 1580
Pub. L. 111-148, 124 Stat. 119, as amended, and the associated 1581
regulations, as well as any other applicable state laws or rules 1582
or federal regulations. 1583

(B) Review of a final adverse benefit determination shall be 1584
through an external review under section 3922.08, 3922.09, or 1585
3922.10 of the Revised Code. 1586

(C) All health plan issuers shall provide notice to covered 1587
persons, pursuant to and in accordance with federal regulations, 1588
of all internal appeal processes, external review processes, the 1589
availability of any applicable office of health insurance 1590
assistance, ombudsman program, or other similar program in this 1591
state to assist consumers. 1592

Sec. 3922.04. (A) Except as provided in division (E) of this 1593
section, a health plan issuer is not required to grant a request 1594
for a standard external review made under section 3922.08 or 1595
3922.10 of the Revised Code until the covered person has exhausted 1596
the health plan issuer's internal appeal process. 1597

(B) An internal appeal process shall be considered exhausted 1598
if a covered person has requested an internal appeal and has not 1599
received a written decision from the health plan issuer within the 1600
time frame required by ~~23~~ 29 C.F.R. 2560.503-1 or the health plan 1601
issuer fails to adhere to all requirements of the internal appeals 1602
process. 1603

(C) Notwithstanding division (B) of this section, the 1604
internal appeals process will not be deemed exhausted based on de 1605
minimis violations that do not cause, and are not likely to cause, 1606
prejudice or harm to the covered person so long as the health plan 1607
issuer demonstrates that the violation was for good cause or due 1608
to matters beyond the control of the health plan issuer and that 1609
the violation occurred in the context of an ongoing, good faith 1610
exchange of information between the health plan issuer and the 1611
covered person, and is not reflective of a pattern or practice of 1612
noncompliance, except that: 1613

(1) If the health plan issuer denies a request for external 1614
review under this division, the covered person may request written 1615
explanation from the health plan issuer, and the health plan 1616
issuer shall provide the explanation within ten days, including a 1617
specific description of its ~~bases~~ basis, if any, for asserting 1618
that the delay should not cause the internal appeals process to be 1619
considered exhausted; 1620

(2) The covered person may request review by the 1621
superintendent of the health plan issuer's explanation provided 1622
under division (C)(1) of this section and if the superintendent 1623
affirms the health plan issuer's explanation, the covered person 1624
may, within ten days of the superintendent's notice of decision, 1625
resubmit and pursue the internal appeal process. Time periods for 1626
refiling the internal appeal shall begin to run upon receipt of 1627
such notice by the covered person. 1628

(D) Notwithstanding division (B) of this section, a covered 1629

person shall not make a request for an external review of an 1630
adverse benefit determination involving a retrospective review 1631
determination made pursuant to a utilization review until the 1632
covered person has exhausted the health plan issuer's internal 1633
appeals process. 1634

(E) A request for an external review of an adverse benefit 1635
determination may be made before the covered person has exhausted 1636
the health plan issuer's internal appeals procedures whenever the 1637
health plan issuer agrees to waive the exhaustion requirement. If 1638
the internal appeal process is waived, the covered person may file 1639
a request in writing for a standard external review under section 1640
3922.08 or 3922.10 of the Revised Code. 1641

(F) Notwithstanding any other section in this chapter, health 1642
plan issuers offering individual health insurance coverage, 1643
including coverage offered to individuals through nonemployer 1644
groups shall not require more than one level of internal appeal 1645
before the individual may request an external review. 1646

Sec. 3922.05. (A) A health plan issuer shall afford the 1647
opportunity for an external review by an independent review 1648
organization for an adverse benefit determination if the 1649
determination involved a medical judgment or if the decision was 1650
based on any medical information, pursuant to the following 1651
sections: 1652

(1) Section 3922.08 of the Revised Code for a standard 1653
review; 1654

(2) Section 3922.09 of the Revised Code for an expedited 1655
review; 1656

(3) Section 3922.10 of the Revised Code for reviews involving 1657
experimental procedures. 1658

(B) A health plan issuer shall afford the opportunity for an 1659

external review by the superintendent of insurance for an adverse 1660
benefit determination by the health plan issuer based on a 1661
contractual issue that did not involve a medical judgment or any 1662
medical information, pursuant to section 3922.11 of the Revised 1663
Code. 1664

(C) For an adverse benefit determination in which emergency 1665
medical services have been determined to be not medically 1666
necessary or appropriate after an external review pursuant to 1667
division (A) of this section, the health plan issuer shall afford 1668
the covered person the opportunity for an external review by the 1669
superintendent of insurance, based on the prudent layperson 1670
standard, pursuant to section 3922.11 of the Revised Code. 1671

(D) Upon receipt of a request for an external review from a 1672
covered person, the health plan issuer shall review it for 1673
completeness as prescribed under any associated rules, policies, 1674
or procedures adopted by the superintendent. 1675

(1) If the request is complete, the health plan issuer shall 1676
initiate an external review in accordance with any associated 1677
rules, policies, or procedures adopted by the superintendent of 1678
insurance and shall notify the covered person in writing, in a 1679
form specified by the superintendent of insurance, that the 1680
request is complete. This notification shall include both of the 1681
following: 1682

(a) The name and contact information for the assigned 1683
independent review organization or the superintendent of 1684
insurance, as applicable, for the purpose of submitting additional 1685
information; 1686

(b) Except for when an expedited request is made under 1687
section 3922.09 or 3922.10 of the Revised Code, a statement that 1688
the covered person may, ~~with~~ within ten business days after the 1689
date of receipt of the notice, submit, in writing, additional 1690

information for either the independent review organization or the 1691
superintendent of insurance to consider when conducting the 1692
external review. 1693

(2) If the request for an external review is not complete, 1694
the health plan issuer shall, in accordance with any associated 1695
rules, policies, or procedures adopted by the superintendent of 1696
insurance, inform the covered person in writing, including what 1697
information is needed to make the request complete. 1698

(E)(1) If the health plan issuer denies a request for an 1699
external review on the basis that the adverse benefit 1700
determination is not eligible for an external review, the health 1701
plan issuer shall notify the covered person in writing of both of 1702
the following: 1703

(a) The reason for the denial; 1704

(b) That the denial may be appealed to the superintendent. 1705

(2) If the health plan issuer denies a request for external 1706
review on the basis that the adverse benefit determination is not 1707
eligible for an external review, the covered person may appeal the 1708
denial to the superintendent of insurance. 1709

(3) Regardless of a determination made by a health plan 1710
issuer, the superintendent of insurance may determine that a 1711
request is eligible for external review. The superintendent's 1712
determination shall be made in accordance with the terms of the 1713
covered person's benefit plan and shall be subject to all 1714
applicable provisions of this chapter. 1715

(F)(1) If an external review of an adverse benefit 1716
determination is granted, the superintendent, according to any 1717
rules, policies, or procedures adopted by the superintendent shall 1718
assign an independent review organization from the list of 1719
organizations maintained by the superintendent under section 1720
3922.13 of the Revised Code to conduct the external review and 1721

shall notify the health plan issuer of the name of the assigned independent review organization. 1722
1723

(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. 1724
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(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. 1729
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(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. 1732
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(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 by the health plan issuer of a request for a standard review or a standard review involving an experimental or investigational treatment, or within seventy-two hours of receipt by the health plan issuer of an expedited request. 1741
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(2) The written notice shall be sent to all of the following: 1748

(a) The covered person; 1749

(b) The health plan issuer; 1750

(c) The superintendent of insurance. 1751

(3) The written notification shall include all of the 1752
following: 1753

(a) A general description of the reason for the request for 1754
external review; 1755

(b) The date the independent review organization was assigned 1756
by the superintendent of insurance to conduct the external review; 1757

(c) The dates over which the external review was conducted; 1758

(d) The date on which the independent review organization's 1759
decision was made; 1760

(e) The rationale for its decision; 1761

(f) References to the evidence or documentation, including 1762
any evidence-based standards used, that were considered in 1763
reaching its decision. 1764

(I) Upon receipt of a notice by an independent review 1765
organization to reverse the adverse benefit determination, a 1766
health plan issuer shall immediately provide coverage for the 1767
health care service or services in question. 1768

Sec. 3922.06. Except for when an expedited request is made 1769
under section 3922.09 or 3922.10 of the Revised Code, an 1770
independent review organization shall forward upon receipt a copy 1771
of any information received from a covered person pursuant to 1772
division (D)(1) of section 3922.05 of the Revised Code, as well as 1773
any other information received from the covered person, to the 1774
health plan issuer. 1775

Upon receipt of that information or the information described 1776
in division (K) of section 3922.10 of the Revised Code, a health 1777
plan issuer may reconsider its adverse benefit determination and 1778
provide coverage for the health service in question. 1779

Reconsideration of an adverse benefit determination by a 1780

health plan issuer based upon receipt of information under this 1781
section shall not delay or terminate an external review. 1782

If a health plan issuer reverses an adverse benefit 1783
determination under this section, the health plan issuer shall 1784
notify, in writing and within one business day of making such a 1785
decision, the covered person, the assigned independent review 1786
organization, and the superintendent of insurance. 1787

Upon receipt of such a notification, the assigned independent 1788
review organization shall terminate the associated external 1789
review. 1790

Sec. 3922.09. (A) A covered person may make a request for an 1791
expedited external review, except as provided in division ~~(J)~~(I) 1792
of this section: 1793

(1) After an adverse benefit determination, if both of the 1794
following apply: 1795

(a) The covered person's treating physician certifies that 1796
the adverse benefit determination involves a medical condition 1797
that could seriously jeopardize the life or health of the covered 1798
person, or would jeopardize the covered person's ability to regain 1799
maximum function, if treated after the time frame of an expedited 1800
internal ~~review~~ appeal; 1801

(b) The covered person has filed a request for an expedited 1802
internal ~~review~~ appeal. 1803

(2) After a final adverse benefit determination, if either of 1804
the following apply: 1805

(a) The covered person's treating physician certifies that 1806
the adverse benefit determination involves a medical condition 1807
that could seriously jeopardize the life or health of the covered 1808
person, or would jeopardize the covered person's ability to regain 1809
maximum function, if treated after the time frame of a standard 1810

external review; 1811

(b) The final adverse benefit determination concerns an 1812
admission, availability of care, continued stay, or health care 1813
service for which the covered person received emergency services, 1814
but has not yet been discharged from a facility. 1815

(B) Immediately upon receipt of a request for an expedited 1816
external review, the health plan issuer shall determine if the 1817
request is complete under any associated rules, policies, or 1818
procedures adopted by the superintendent of insurance and eligible 1819
for expedited external review under division ~~(B)~~(A) of this 1820
section. The health plan issuer shall immediately notify the 1821
covered person of its determination in accordance with any 1822
associated rules, policies, or procedures adopted by the 1823
superintendent of insurance. 1824

(C) If a request for an expedited review is complete and 1825
eligible, the health plan issuer shall immediately provide or 1826
transmit all necessary documents and information considered in 1827
making the adverse benefit determination in question to the 1828
assigned independent review organization electronically, or by 1829
~~telephone~~, facsimile, or other available expeditious method. 1830

(D) In addition to the information transmitted under division 1831
~~(D)~~(C) of this section, the assigned independent review 1832
organization shall also consider relevant information as required 1833
under section 3922.07 of the Revised Code. 1834

(E) As expeditiously as the covered person's medical 1835
condition requires, but no more than seventy-two hours after ~~being~~ 1836
~~assigned~~ receipt by the health plan issuer of a request for an 1837
expedited, external review, the assigned independent review 1838
organization shall uphold or reverse the adverse benefit 1839
determination. 1840

(F) If a health plan issuer fails to provide the documents 1841

and information as required in division ~~(D)~~(C) of this section, 1842
the independent review organization shall not delay the external 1843
review and may accordingly reverse the adverse benefit 1844
determination. 1845

(G) An independent review organization shall promptly notify 1846
the covered person, health plan issuer, and superintendent of 1847
insurance of any decision made under this section. If such a 1848
notice is not made in writing, the independent review 1849
organization, shall provide, within forty-eight hours of making 1850
the decision, written confirmation, including the information 1851
required under division (H)(3) of section 3922.05 of the Revised 1852
Code, of its decision to the covered person, the health plan 1853
issuer, and the superintendent of insurance. 1854

(H) Upon receipt of a notice by an independent review 1855
organization to reverse the adverse benefit determination, a 1856
health plan issuer shall immediately provide coverage for the 1857
health care service or services in question. 1858

(I) An expedited, external review may not be provided for 1859
retrospective final adverse benefit determinations. 1860

Sec. 3922.10. The provisions of this section apply only to 1861
external reviews that involve an experimental or investigational 1862
treatment. 1863

(A) A covered person may request an external review of an 1864
adverse benefit determination based on the conclusion that a 1865
requested health care service is experimental or investigational, 1866
except when the requested health care service is explicitly listed 1867
as an excluded benefit under the covered person's benefit plan. 1868

(B) To be eligible for an external review under this section, 1869
a covered person's treating physician shall certify that one of 1870
the following situations is applicable: 1871

(1) Standard health care services have not been effective in improving the condition of the covered person+. 1872
1873

(2) Standard health care services are not medically appropriate for the covered person+. 1874
1875

(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. 1876
1877
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(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. 1879
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(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. 1884
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(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: 1892
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1894
1895

(1) Within five days after the receipt of a request for ~~an a~~ standard external review; 1896
1897

(2) For an expedited external review, immediately electronically, or by ~~telephone,~~ facsimile, or any other available expeditious method. 1898
1899
1900

(E) An independent review organization assigned by the 1901

superintendent of insurance under division (F) of section 3922.05 1902
of the Revised Code shall do both of the following: 1903

(1) Select at least one clinical reviewer, pursuant to 1904
divisions (F) and (G) of this section to conduct the external 1905
review; 1906

(2) Make a decision to uphold or reverse the adverse benefit 1907
determination based upon the opinion of the clinical reviewer or 1908
reviewers. 1909

(F) In selecting clinical reviewers under division (E) of 1910
this section, the assigned independent review organization shall 1911
select physicians or other health care professionals who meet the 1912
minimum qualifications described in section 3922.15 of the Revised 1913
Code, ~~and through clinical experience in the last three years, are~~ 1914
~~experts in the treatment of the covered person's condition and~~ 1915
~~have knowledge of the requested health care service.~~ 1916

(G) Neither the covered person, nor the health plan issuer, 1917
shall choose or have any influence over the choice of the clinical 1918
reviewer or reviewers chosen under division (E) of this section. 1919

(H)(1) Each chosen clinical reviewer shall provide a written 1920
opinion to the assigned independent review organization on whether 1921
the adverse benefit determination should be upheld or reversed. 1922

(2) In reaching such opinions, a clinical reviewer is not 1923
bound by any conclusions reached by the health plan issuer during 1924
a utilization review process or its internal appeals process. 1925

(3) Any such opinion shall be in writing and shall include 1926
all of the following information: 1927

(a) A description of the covered person's condition; 1928

(b) A description of the indicators relevant to determining 1929
whether there is sufficient evidence to demonstrate that the 1930
recommended or requested therapy is more likely than not to be 1931

more beneficial to the covered person than any available standard 1932
health care service, and that the adverse risks of the requested 1933
health care service would not be substantially greater than those 1934
of available standard health care services; 1935

(c) A description and analysis of any medical or scientific 1936
evidence considered in reaching the opinion; 1937

(d) A description and analysis of any evidence-based standard 1938
considered; 1939

(e) Information on whether the reviewer's rationale for the 1940
opinion is based on division ~~(L)(2)~~(K)(2)(b) or ~~(L)(3)(c)~~ of this 1941
section. 1942

(I) An external review shall not be delayed due to failure on 1943
the part of the health plan issuer to provide the information 1944
required under division (D) of this section. 1945

(J)(1) An independent review organization may reverse an 1946
adverse benefit determination, if the information required under 1947
division (D) of this section is not provided in the allotted time. 1948
The ~~external~~ independent review ~~committee~~ organization may also 1949
grant a request from the health plan issuer for more time to 1950
provide the required information. 1951

(2) If an adverse benefit determination is reversed under 1952
division (J)(1) of this section, the independent review 1953
organization shall immediately notify the covered person, the 1954
health plan issuer, and the superintendent of insurance. 1955

(K)(1) Each clinical reviewer shall review all of the 1956
information received pursuant to division (D) of this section, as 1957
well as any other information submitted in writing by the covered 1958
person pursuant to division (D) of section 3922.05 of the Revised 1959
Code. 1960

(2) In addition to the documents and information provided 1961

pursuant to division (D) of this section and division (D) of 1962
section 3922.05 of the Revised Code, each clinical reviewer shall 1963
consider the following: 1964

(a) Information required under section 3922.07 of the Revised 1965
Code; 1966

(b) Whether the requested health care service has been 1967
approved by the federal food and drug administration, if 1968
applicable, for the condition; 1969

(c) Whether medical or scientific evidence, or evidence-based 1970
standards, demonstrate that the expected benefits of the requested 1971
health care service is more likely than not to be beneficial to 1972
the covered person than any available standard health care 1973
service, and that the adverse risks of the requested health care 1974
service would not be substantially greater than those of available 1975
standard health care services. 1976

(L) Within one business day after the receipt of any such 1977
information submitted by the covered person in accordance with 1978
division (K)(1) of this section, the independent review 1979
organization shall forward the information to the health plan 1980
issuer. Upon receipt of any such forwarded information in 1981
accordance with division (K)(1) of this section, a health plan 1982
issuer may reconsider its adverse benefit determination ~~under~~ as 1983
described in section 3922.06 of the Revised Code. 1984

(M)(1) Within thirty days after the date of receipt by the 1985
health plan issuer of a request for a standard external review, or 1986
within seventy-two hours of receipt by the health plan issuer of a 1987
request for an expedited external review, the assigned independent 1988
review organization shall provide written notice of its decision 1989
to uphold or reverse the adverse benefit determination to the 1990
covered person, the health plan issuer, and the superintendent of 1991
insurance. 1992

(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	2024
by the superintendent to conduct the external review;	2025
(d) The dates over which the external review was conducted;	2026
(e) The date of its decision;	2027
(f) The principal reason or reasons for its decision;	2028
(g) The rationale for its decision.	2029
(N) Upon receipt of a notice of a decision by an independent	2030
review organization pursuant to division (M)(1) of this section	2031
reversing the adverse benefit determination, a health plan issuer	2032
shall immediately provide coverage of the requested health care	2033
service in question.	2034
Sec. 3922.11. (A) The superintendent of insurance shall	2035
establish and maintain a system for receiving and reviewing	2036
requests for external review for adverse benefit determinations	2037
where the determination by the health plan issuer was based on a	2038
contractual issue and did not involve a medical judgment or a	2039
determination based on any medical information, except for	2040
emergency services, as specified in division (C) of section	2041
3922.05 of the Revised Code.	2042
(B) A health plan issuer shall submit a request for external	2043
review pursuant to division (B) or (C) of section 3922.05 of the	2044
Revised Code to the superintendent, in accordance with any	2045
associated rules, policies, or procedures adopted by the	2046
superintendent of insurance.	2047
(C) On receipt of a request from a health plan issuer, the	2048
superintendent shall consider whether the health care service is a	2049
service covered under the terms of the covered person's policy,	2050
contract, certificate, or agreement, except that the	2051
superintendent shall not conduct a review under this section	2052
unless the covered person has exhausted the health plan issuer's	2053

internal ~~review~~ appeal process, pursuant to sections 3922.03 and 2054
3922.04 of the Revised Code. The health plan issuer and covered 2055
person shall provide the superintendent with any information 2056
required by the superintendent that is in their possession and is 2057
germane to the review. 2058

(D) Unless the superintendent is not able to do so because 2059
making the determination requires a medical judgement or a 2060
determination based on medical information, the superintendent 2061
shall determine whether the health care service at issue is a 2062
service covered under the terms of the covered person's contract, 2063
policy, certificate, or agreement. The superintendent shall notify 2064
the covered person, and the health plan issuer of the 2065
superintendent's determination. 2066

(E) If the superintendent notifies the health plan issuer 2067
that making the determination requires a medical judgement or a 2068
determination based on medical information, the health plan issuer 2069
shall initiate an external review under this chapter. 2070

(F) If the superintendent determines that the health service 2071
is a covered service, the health plan issuer shall cover the 2072
service. 2073

(G) If the superintendent determines that the health care 2074
service is not a covered service, the health plan issuer is not 2075
required to cover the service or afford the enrollee covered 2076
person an external review by an independent review organization. 2077

Sec. 3922.14. (A) To be accredited by the superintendent of 2078
insurance to conduct external reviews under section 3922.13 of the 2079
Revised Code, in addition to the requirements provided in section 2080
3922.13 of the Revised Code and any associated rules adopted by 2081
the superintendent, an independent review organization shall do 2082
all of the following: 2083

(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 2114
by, or exercise control with a ~~benefit~~ health plan issuer, a 2115
national, state or local trade association of ~~benefit-plans~~ health 2116
plan issuers, or a national, state, or local trade association of 2117
health care providers. 2118

(C)(1) Neither the independent review organization selected 2119
to conduct the external review nor any clinical reviewer assigned 2120
by the independent organization to conduct the external review may 2121
have a material, professional, familial, or financial affiliation 2122
with any of the following: 2123

(a) The health plan issuer that is the subject of the 2124
external review, or any officer, director, or management employee 2125
of the health plan issuer; 2126

(b) The covered person whose treatment is the subject of the 2127
external review; 2128

(c) The health care provider, or the health care provider's 2129
medical group or independent practice association, recommending 2130
the health care service or treatment that is the subject of the 2131
external review; 2132

(d) The facility at which the recommended health care service 2133
would be provided; 2134

(e) The developer or manufacturer of the principal drug, 2135
device, procedure, or other therapy being recommended for the 2136
covered person whose treatment is the subject of the external 2137
review. 2138

(2) The superintendent may make a determination as to whether 2139
an independent review organization or a clinical reviewer of the 2140
independent review organization has a material professional, 2141
familial, or financial conflict of interest for purposes of 2142
division (C)(1) of this section. In making this determination, the 2143
superintendent may take into consideration situations where an 2144

independent review organization, or a clinical reviewer, may have 2145
an apparent conflict of interest, but that the characteristics of 2146
the relationship or connection in question are such that they do 2147
not fall under the definition of conflict of interest provided 2148
under division (D)(1) of this section. If the superintendent 2149
determines that a conflict of interest exists, the superintendent 2150
shall disallow an independent review organization or a clinical 2151
reviewer from conducting the external review in question. Such 2152
determinations related to conflicts of interest are the sole 2153
discretion of the superintendent of insurance. 2154

(D)(1) An independent review organization that is accredited 2155
by a nationally recognized private accrediting entity that has 2156
independent review accreditation standards that the superintendent 2157
has determined are equivalent to or exceed the minimum 2158
qualifications of this section shall be presumed in compliance 2159
with this section to be eligible for accreditation by the 2160
superintendent under section 3922.14 of the Revised Code. 2161

(2) The superintendent shall initially review and 2162
periodically review the independent review organization 2163
accreditation standards of a nationally recognized private 2164
accrediting entity to determine whether the entity's standards 2165
are, and continue to be, equivalent to or exceed the minimum 2166
qualifications established under this section. The superintendent 2167
may accept a review conducted by the national association of 2168
insurance commissioners for the purpose of the determination under 2169
this division. 2170

(3) Upon request, a nationally recognized, private 2171
accrediting entity shall make its current independent review 2172
organization accreditation standards available to the 2173
superintendent or the national association of insurance 2174
commissioners in order for the superintendent to determine if the 2175
entity's standards are equivalent to or exceed the minimum 2176

qualifications established under this section. The superintendent 2177
may exclude any private accrediting entity that is not reviewed by 2178
the national association of insurance commissioners. 2179

(E) An independent review organization shall be unbiased in 2180
its review of adverse benefit determinations and shall establish 2181
and maintain written procedures to ensure that it is unbiased. 2182

Sec. 3922.15. All clinical reviewers assigned by an 2183
independent review organization to conduct external reviews shall 2184
have the same license as the health care provider of the service 2185
in question, and shall be physicians or other appropriate health 2186
care providers who meet all of the following minimum 2187
qualifications: 2188

(A) Be an expert in the treatment of the medical condition 2189
that is the subject of the external review; 2190

(B) Be knowledgeable about the requested health care service 2191
through clinical experience, within the last three years, treating 2192
patients with the same, or a similar, medical condition, and, in 2193
the case of an external review of an experimental or 2194
investigational health care service, be an expert, through 2195
clinical experience in the last three years, in the treatment of 2196
the covered person's condition and have knowledge of the requested 2197
health care service; 2198

(C) Hold a nonrestricted license in a state of the United 2199
States and, for physicians, a current certification by a 2200
recognized American medical specialty board in the area or areas 2201
appropriate to the subject of the external review; 2202

(D) Have no history of disciplinary actions or sanctions, 2203
including loss of staff privileges or participation restrictions, 2204
that have been taken or are pending by any hospital, governmental 2205
agency or unit, or regulatory body that raise a question as to the 2206

clinical reviewer's physical, mental, or professional competence 2207
or moral character. 2208

Sec. 3922.16. (A) Nothing in this chapter shall be construed 2209
to create a cause of action against any of the following: 2210

(1) An employer that provides health care benefits to 2211
employees through a health plan issuer; 2212

(2) A clinical reviewer, ~~medical expert~~, or independent 2213
review organization that participates in an external review under 2214
this chapter; 2215

(3) A health plan issuer that provides coverage for benefits 2216
pursuant to this chapter. 2217

(B) An independent review organization and any ~~medical expert~~ 2218
~~or~~ clinical reviewer an independent review organization uses in 2219
conducting an external review under this chapter is not liable in 2220
damages in a civil action for injury, death, or loss to person or 2221
property and is not subject to professional disciplinary action 2222
for making, in good faith, any finding, conclusion, or 2223
determination required to complete the external review. 2224

(C) This section does not grant immunity from civil liability 2225
or professional disciplinary action to an independent review 2226
organization, ~~medical expert~~, or clinical peer reviewer for an 2227
action that is outside the scope of authority granted under this 2228
chapter. 2229

Sec. 3922.19. (A) Each health plan issuer shall include a 2230
description of its external review procedures, including the 2231
superintendent's contractual review, in, or attached to, the 2232
policy, certificate, membership booklet, or outline of coverage, 2233
or other evidence of coverage it provides to covered persons. This 2234
disclosure shall be in a form prescribed by the superintendent in 2235
any associated rules, policies, or procedures. 2236

(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;	2267 2268
(d) A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal and an external review;	2269 2270 2271
(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.	2272 2273 2274 2275
(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.	2276 2277 2278 2279
(4) Any written notice provided under division (C) of this section shall be in a form prescribed by the superintendent of insurance.	2280 2281 2282
(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:	2283 2284 2285 2286 2287
(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.	2288 2289 2290 2291 2292 2293 2294 2295 2296
(2) If the adverse benefit determination involves a denial of	2297

coverage based on a determination that the recommended or 2298
requested health care service or treatment is experimental or 2299
investigational and the covered person's treating physician 2300
certifies in writing that the recommended or requested health care 2301
service or treatment that is the subject of the adverse benefit 2302
determination would be significantly less effective if not 2303
promptly initiated, the covered person may file a request for an 2304
expedited external review to be conducted simultaneously with the 2305
expedited internal appeal, pursuant to section 3922.09 or 3922.10 2306
of the Revised Code. 2307

(3) If the covered person has requested an internal appeal 2308
and the health plan issuer has not issued a written decision to 2309
the covered person within thirty days following the date the 2310
covered person files the request, and the covered person has not 2311
requested or agreed to a delay, the covered person may file a 2312
request for external review pursuant to section 3922.08 of the 2313
Revised Code and may be considered to have exhausted the health 2314
plan issuer's internal appeals process for purposes of section 2315
3922.04 of the Revised Code. 2316

(E) For a final adverse benefit determination, the health 2317
plan issuer shall include with the notice required under division 2318
(C) of this section a statement informing the covered person of 2319
all of the following: 2320

(1) A written request for an external review must be 2321
submitted to the health plan issuer within one hundred eighty days 2322
after the date of the notice of final adverse benefit 2323
determination. 2324

(2) If the covered person's treating physician certifies in 2325
writing that the covered person has a medical condition for which 2326
the time frame for completion of a standard external review 2327
pursuant to section 3922.08 of the Revised Code would seriously 2328
jeopardize the life or health of the covered person or would 2329

jeopardize the covered person's ability to regain maximum 2330
function, the covered person may file a request for an expedited 2331
external review pursuant to section 3922.09 of the Revised Code. 2332

(3)(a) If the final adverse benefit determination concerns a 2333
health care service for which the covered person received 2334
emergency services, but has not been discharged from a facility, 2335
the covered person may request an expedited external review 2336
pursuant to section 3922.09 of the Revised Code. 2337

(b) If the final adverse benefit determination concerns 2338
denial of coverage based on a determination that the recommended 2339
or requested health care service or treatment is experimental or 2340
investigational, the covered person may file a request for an 2341
external review to be conducted pursuant to section 3922.10 of the 2342
Revised Code, or if the covered person's treating physician 2343
certifies in writing that the recommended or requested health care 2344
service that is the subject of the request would be significantly 2345
less effective if not promptly initiated, the covered person may 2346
request an expedited external review to be conducted under section 2347
3922.10 of the Revised Code. 2348

(F)(1) In addition, to any information required to be 2349
provided under divisions (D) and (E) of this section, the health 2350
plan issuer shall include a description of both the standard and 2351
expedited external review procedures the health plan issuer is 2352
required to produce pursuant to this chapter, highlighting in the 2353
external review procedures the sections of the Revised Code that 2354
give the covered person the opportunity to submit additional 2355
information. 2356

(2) The health plan issuer shall also include any forms used 2357
to process an external review, including an authorization form, or 2358
other document approved by the superintendent that complies with 2359
the requirements of 45 C.F.R. 164.508, by which the covered 2360
person, for purposes of conducting an external review under this 2361

chapter, authorizes the health plan issuer and the covered 2362
person's treating health care provider to disclose protected 2363
health information, including medical records, concerning the 2364
covered person that are related in any manner to the external 2365
review. 2366

Sec. 3925.08. Funds accumulated in the course of business, or 2367
surplus money above the capital stock, of any company organized 2368
under any law of this state, for the purpose provided in section 2369
3925.01 of the Revised Code, shall only be loaned or invested in 2370
the securities listed in sections 3925.05 and 3925.06 of the 2371
Revised Code, or in the following: 2372

(A)(1) Bonds and mortgages on unencumbered real estate within 2373
this or any other state worth twenty-five per cent more than the 2374
sum loaned thereon, exclusive of buildings, unless such buildings 2375
are insured in some company authorized to do business in this 2376
state, and the policy is transferred to the company making the 2377
investment; or, in lieu of transferring such policies, the 2378
mortgagee may purchase a policy or policies of mortgage protection 2379
insurance, payable to the mortgagee or a trustee in its behalf, 2380
insuring the mortgagee against loss resulting from the failure of 2381
the mortgagor to acquire and maintain, from such an authorized 2382
insurance company, insurance in the amount required by this 2383
section; 2384

(2) Bonds or notes secured by mortgages insured by the 2385
federal housing administrator; 2386

(3) Loans to veterans guaranteed in whole or in part by the 2387
United States pursuant to Title III of the "Servicemen's 2388
Readjustment Act of 1944," 58 Stat. 284, 38 U.S.C. 693, as 2389
amended, provided such guaranteed loans are liens upon real 2390
estate. 2391

(B)(1) Legally authorized and executed bonds, notes, 2392

warrants, and securities which are the direct obligation of or are 2393
guaranteed as to both principal and interest by Canada, or which 2394
are the direct obligation of or are guaranteed as to both 2395
principal and interest by any province of Canada, or which are the 2396
direct obligation of or are guaranteed as to both principal and 2397
interest by any municipal corporation of Canada having a 2398
population of one hundred thousand or more by the latest official 2399
census, and which are not in default as to principal or interest; 2400

(2) Obligations issued, assumed, or guaranteed by the 2401
international finance corporation or by the international bank for 2402
reconstruction and development, the Asian development bank, the 2403
inter-American development bank, the African development bank, or 2404
similar development bank in which the president, as authorized by 2405
congress and on behalf of the United States, has accepted 2406
membership. 2407

(C) Bonds or other evidences of indebtedness, not in default 2408
as to principal or interest, which are valid obligations issued, 2409
assumed, or guaranteed by the United States, by any state thereof, 2410
the Commonwealth of Puerto Rico, by any territory or insular 2411
possession of the United States, or by the District of Columbia, 2412
or which are valid obligations issued, assumed, or guaranteed by 2413
any county, municipal corporation, district, or political 2414
subdivision, or by any civil division or public instrumentality of 2415
such governmental units, if by statutory or other legal 2416
requirements such obligations are payable, as to both principal 2417
and interest, from taxes levied upon all taxable property within 2418
the jurisdiction of such governmental unit, or in bonds or other 2419
obligations issued by or for account of any such governmental unit 2420
having a population of five thousand or more by the latest 2421
official federal or state census, which are payable as to both 2422
principal and interest from revenues or earnings from the whole or 2423
any part of a publicly owned utility, provided that by statute or 2424

other applicable legal requirements, rates from the service or 2425
operation of such utility must be fixed, maintained, and collected 2426
at all times so as to produce sufficient revenues or earnings to 2427
pay both principal and interest of such bonds or obligations as 2428
they become due, and in any bonds or obligations issued or 2429
guaranteed by the United States, any state, the District of 2430
Columbia, the Commonwealth of Puerto Rico, any county, municipal 2431
corporation, district, political subdivision, civil division, 2432
commission, board, authority, agency, or other instrumentality of 2433
one or more of them, provided there is a specific pledge of 2434
revenues, earnings, or other adequate security and provided that 2435
no prior or parity obligation of the same issuer, payable from 2436
revenues or earnings from the same source, has been in default as 2437
to principal or interest during the five years next preceding the 2438
date of such investment, but such issuer need not have been in 2439
existence for that period, and obligations acquired under this 2440
section may be newly issued, and further provided that there is 2441
adequate provision for payment of expenses of operation and 2442
maintenance and the principal and interest on all obligations when 2443
due; 2444

(D)(1) Bonds or other evidences of indebtedness, bearing or 2445
accruing interest, issued, assumed, or guaranteed by any solvent 2446
corporation, trust, partnership, or similar business entity 2447
organized and existing under the laws of this or any other state, 2448
or of the United States, the Commonwealth of Puerto Rico, or of 2449
the District of Columbia, or of Canada or any province of Canada, 2450
upon which there is no existing interest or principal default, 2451
provided that either: 2452

(a) The bonds or other evidences of indebtedness are rated 1 2453
or 2 by the securities valuation office of the national 2454
association of insurance commissioners; 2455

(b) The corporation, together with its predecessor 2456

corporation or corporations, or the trust, partnership, or similar 2457
business entity, has been in existence for a period of at least 2458
five years. 2459

(2) Stocks ~~or~~, limited liability company membership 2460
interests, limited partnership interests, or limited liability 2461
partnership interests of any insurance, financial, investment, ~~and~~ 2462
or investment management companies, which investment management 2463
companies are registered with the securities and exchange 2464
commission under the "Investment Company Act of 1940," 54 Stat. 2465
789, 15 U.S.C. 80a-1, as amended, or the stocks, limited liability 2466
company membership interests, limited partnership interests, or 2467
limited liability partnership interests in an entity wholly owned 2468
by a domestic company or by a domestic company and its affiliates, 2469
that is formed and maintained to acquire or hold specific assets 2470
or liabilities for bankruptcy remoteness or limitation of 2471
liability purposes, except its own stock, and stocks ~~or~~, limited 2472
liability company membership interests, limited partnership 2473
interests, limited liability partnership interests, bonds, notes, 2474
and debentures of any company which is organized for, and limited 2475
in its operations to, the financing of insurance premiums, upon 2476
approval of such investments by the superintendent of insurance; 2477
except that approval shall not be required for the purchase of the 2478
outstanding stocks ~~or~~, limited liability company membership 2479
interests, limited partnership interests, or limited liability 2480
partnership interests of any such company, if investment in each 2481
such company does not exceed in the aggregate two and one-half per 2482
cent of the total admitted assets of the company making the 2483
investment as of the preceding thirty-first day of December. 2484
Whenever the superintendent has reason to believe that the 2485
retention, investment, or acquisition of the stock ~~or~~, limited 2486
liability company membership interest, limited partnership 2487
interest, or limited liability partnership interest of any such 2488
company substantially lessens competition generally in the 2489

business of insurance or creates a monopoly therein the 2490
superintendent shall proceed under section 3901.13 of the Revised 2491
Code to cause such domestic insurance company to divest itself of 2492
such stock ~~or~~, limited liability company membership interest, 2493
limited partnership interest, or limited liability partnership 2494
interest. 2495

(3) Other stocks, limited liability company membership 2496
interests, or limited partnership interests, or limited liability 2497
partnership interests of any solvent corporation organized under 2498
the laws of this or any other state, or of the United States, or 2499
of the District of Columbia, or of Canada or any province of 2500
Canada, provided that a dividend or distribution has been paid by 2501
the ~~corporation~~ business entity in the preceding twelve months 2502
upon the stock, membership interest, or partnership interest to be 2503
purchased or such ~~corporation~~ business entity, together with its 2504
predecessor ~~corporation~~ entity or ~~corporations~~ entities, has been 2505
in existence for a period of at least five years. 2506

(4) A domestic company may acquire, hold, and convey tangible 2507
personal property or interests therein for the production of 2508
income, provided no domestic company shall invest in excess of two 2509
per cent of its admitted assets as of the preceding thirty-first 2510
day of December under this division. 2511

(5) In equipment trust obligations or certificates, security 2512
agreements, or other evidences of indebtedness entered into 2513
directly or guaranteed by any company operating wholly or partly 2514
within the United States or Canada, provided that such debt 2515
obligation is secured by a first lien on tangible personal 2516
property which is purchased or secured for payment thereof and 2517
such debt obligation is repayable within twenty years from the 2518
date of issue in annual, semiannual, or more frequent installments 2519
beginning not later than the first year after such date. 2520

(6) An insurer may invest without limitation in investments 2521

of government money market funds. As used in division (D)(6) of 2522
this section, "government money market fund" means a fund that at 2523
all times invests in obligations issued, guaranteed, or insured by 2524
the federal government of the United States or collateralized 2525
repurchase agreements comprised of such obligations, and that 2526
qualifies for investment without a reserve pursuant to the 2527
purposes and procedures of the securities valuation office of the 2528
national association of insurance commissioners. 2529

(E) Negotiable promissory notes maturing in not more than six 2530
months from the date thereof, secured by collateral security 2531
through the transfer of any of the classes of securities described 2532
in this section or in sections 3925.05 and 3925.06 of the Revised 2533
Code, with absolute power of sale within twenty days after default 2534
in payment at maturity; 2535

(F)(1) Repurchase agreements with, and interest-bearing 2536
obligations, including savings accounts and time certificates of 2537
deposit of, a national bank of the United States, a commonwealth 2538
bank of Puerto Rico, a chartered bank of Canada, or a state bank, 2539
provided such bank is either a member of the federal deposit 2540
insurance corporation created pursuant to the "Banking Act of 2541
1933," as amended, or the Canada deposit insurance corporation 2542
created pursuant to the act of parliament known as the "Canada 2543
Deposit Insurance Corporation Act," as amended. 2544

(2) Certificates of deposit, savings share accounts, 2545
investment share accounts, stock deposits, stock certificates, or 2546
other evidences of indebtedness of a savings and loan association, 2547
provided all such evidences of indebtedness are insured pursuant 2548
to the "Financial Institutions Reform, Recovery, and Enforcement 2549
Act of 1989," 103 Stat. 183, 12 U.S.C.A. 1811, as amended; 2550

(3) Bankers' acceptances and bills of exchange of the kinds 2551
and maturities made eligible by law for rediscount with the 2552
federal reserve banks, provided that the same are accepted by a 2553

bank or trust company incorporated under the laws of the United 2554
States or of this state or any other bank or trust company which 2555
is a member of the federal reserve system. 2556

(G) Any securities issued as a result of any reorganization, 2557
or capital or debt adjustment, in whole or in part, in exchange 2558
for securities acquired by it prior to such reorganization, or 2559
capital or debt adjustment; 2560

(H)(1) In bonds, notes, debentures, or other evidences of 2561
indebtedness issued, assumed, or guaranteed by a solvent 2562
corporation, trust, or partnership formed or existing under the 2563
laws of a foreign jurisdiction, provided each such foreign 2564
investment is of the same kind and quality as United States 2565
investments authorized under this section; or in common or 2566
preferred stock ~~or~~, shares, membership interests, or partnership 2567
interests of any solvent ~~corporation~~ business entity formed or 2568
existing under the laws of a foreign jurisdiction, provided each 2569
such foreign investment is of the same kind and quality as United 2570
States investments authorized under this section; or in bonds or 2571
other evidences of indebtedness issued, assumed, or guaranteed by 2572
a foreign jurisdiction. 2573

An insurer shall not invest in foreign investments under 2574
division (H) of this section, including investments denominated in 2575
foreign currency, a sum exceeding in the aggregate fifteen per 2576
cent of its admitted assets as of the preceding thirty-first day 2577
of December. The aggregate amount of investments held by an 2578
insurer in a single foreign jurisdiction shall not exceed three 2579
per cent of its admitted assets as of the preceding thirty-first 2580
day of December. 2581

As used in division (H)(1) of this section, "foreign 2582
jurisdiction" means a jurisdiction outside the United States, 2583
Puerto Rico, or Canada whose bonds are rated 1 by the securities 2584
valuation office of the national association of insurance 2585

commissioners. 2586

(2) An insurer may acquire investments denominated in foreign 2587
currency whether or not they are foreign investments. 2588

An insurer shall not invest in investments denominated in 2589
foreign currency a sum exceeding in the aggregate ~~ten~~ fifteen per 2590
cent of its admitted assets as of the preceding thirty-first day 2591
of December. The aggregate amount of investments denominated in a 2592
single foreign currency held by an insurer shall not exceed three 2593
per cent of an insurer's admitted assets as of the preceding 2594
thirty-first day of December. 2595

(3) As used in division (H) of this section, "foreign 2596
currency" means a currency other than that of the United States. 2597

(I)(1) Any securities or other property not permitted under 2598
section 3925.05, 3925.06, 3925.08, or 3925.20 of the Revised Code 2599
to an extent not exceeding in the aggregate six per cent of the 2600
total admitted assets of such company on the preceding 2601
thirty-first day of December, within the limitations prescribed in 2602
division (J) of this section. Any such company may also invest up 2603
to an additional five per cent of the total admitted assets of 2604
such company on the preceding thirty-first day of December, within 2605
the limitations prescribed in division (J) of this section, in 2606
loans or investments in small businesses having more than half of 2607
their assets or employees in this state and in venture capital 2608
firms having an office within this state, provided that, as a 2609
condition of a company making an investment in a venture capital 2610
firm, the firm must agree to use its best efforts to make 2611
investments, in an aggregate amount at least equal to the 2612
investment to be made by the company in that venture capital firm, 2613
in small businesses having their principal offices within this 2614
state and having either more than one-half of their assets within 2615
this state or more than one-half of their employees employed 2616
within this state. 2617

As used in division (I) of this section: 2618

(a) "Small businesses" means any corporation, partnership, 2619
proprietorship, or other entity that either does not have more 2620
than four hundred employees, or would qualify as a small business 2621
for the purpose of receiving financial assistance from small 2622
business investment companies licensed under the "Small Business 2623
Investment Act of 1958," 72 Stat. 689, 15 U.S.C.A. 661, as 2624
amended, and rules of the small business administration. 2625

(b) "Venture capital firms" means any corporation, 2626
partnership, proprietorship, or other entity, the principal 2627
business of which is or will be the making of investments in small 2628
businesses. 2629

(c) "Investments" means any equity investment, including 2630
limited partnership interests and other equity interests in which 2631
liability is limited to the amount of the investment, but does not 2632
include general partnership interests or other interests involving 2633
general liability. 2634

(2) In the event that, subsequent to being made under this 2635
division, a loan or investment is determined to have become 2636
qualified as a loan or investment under any of the divisions (A) 2637
to (F) of this section or under section 3925.05, 3925.06, or 2638
3925.20 of the Revised Code, the company may consider such loan or 2639
investment as held under such other statutory provision and such 2640
loan or investment shall no longer be considered as having been 2641
made under this division. 2642

(J) No domestic insurance company shall at any time have 2643
invested a sum exceeding five per cent of its admitted assets as 2644
of the preceding thirty-first day of December in the bonds, notes, 2645
debentures, other evidences of indebtedness, and stocks of a 2646
particular corporation, trust, partnership, or similar business 2647
entity, except for investments authorized under divisions (A) and 2648

(D)(2) of this section, and no domestic insurance company together 2649
with its subsidiary, if any, shall at any time own directly or 2650
indirectly more than twenty-five per cent of the outstanding 2651
bonds, notes, debentures, other evidences of indebtedness, and 2652
stocks of any corporation, except for investments authorized under 2653
divisions (A) and (D)(2) of this section. 2654

This section does not affect the propriety or legality of an 2655
investment made by such domestic insurance company which was in 2656
accordance with the laws in force at the time of the making of the 2657
investment. 2658

Section 2. That existing sections 3903.81, 3907.14, 3921.10, 2659
3921.13, 3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, 2660
3921.33, 3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 2661
3922.09, 3922.10, 3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 2662
3925.08 and section 3921.35 of the Revised Code are hereby 2663
repealed. 2664

Section 3. That sections 3903.81, 3921.10, 3921.13, 3921.19, 2665
3921.22, 3921.28, 3921.29, 3921.30, 3921.31, and 3921.33 of the 2666
Revised Code, as amended by Sections 1 and 2 of this act shall 2667
take effect January 1, 2013. 2668