

**As Reported by the Senate Insurance and Financial Institutions
Committee**

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Sub. H. B. No. 511

Representative Sears

**Cosponsors: Representatives Boose, Grossman, Henne, Romanchuk,
Smith, Wachtmann, Young, Amstutz, Beck, Blessing, Burkley, Conditt,
Green, Hackett, Hill, Scherer, Thompson Speaker Batchelder**

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A B I L L

To amend sections 1739.061, 1751.14, 1751.69, 1
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 2
3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3
3924.01, 4123.01, 4123.026, and 4123.46, and to 4
enact sections 505.377, 737.082, and 737.222 of 5
the Revised Code to clarify the status of 6
volunteer firefighters for purposes of the Patient 7
Protection and Affordable Care Act, to make 8
changes regarding coverage for a dependent child 9
under a parent's health insurance plan and the 10
hours of work needed to qualify for coverage under 11
a small employer health benefit plan, to make 12
changes to the chemotherapy parity law, to make 13
peace officers, firefighters, and emergency 14
medical workers diagnosed with post-traumatic 15
stress disorder arising from employment without an 16
accompanying physical injury eligible for 17
compensation and benefits under Ohio's Workers' 18
Compensation Law, and to increase the duration of 19
the health insurance considered to be short-term 20

under certain insurance laws. 21

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

Section 1. That sections 1739.061, 1751.14, 1751.69, 22
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 23
3923.65, 3923.83, 3923.85, 3924.01, 4123.01, 4123.026, and 4123.46 24
be amended and sections 505.377, 737.082, and 737.222 of the 25
Revised Code be enacted to read as follows: 26

Sec. 505.377. A volunteer firefighter appointed pursuant to 27
this chapter is a bona fide volunteer and not an employee for 28
purposes of section 513 of the "Patient Protection and Affordable 29
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 30
providing those fire protection services, the volunteer receives 31
any of the benefits provided in Chapter 146., 4121., or 4123. or 32
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 33
Code. 34

Sec. 737.082. A volunteer firefighter appointed pursuant to 35
this chapter is a bona fide volunteer and not an employee for 36
purposes of section 513 of the "Patient Protection and Affordable 37
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 38
providing those fire protection services, the volunteer receives 39
any of the benefits provided in Chapter 146., 4121., or 4123. or 40
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 41
Code. 42

Sec. 737.222. A volunteer firefighter appointed pursuant to 43
this chapter is a bona fide volunteer and not an employee for 44
purposes of section 513 of the "Patient Protection and Affordable 45
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 46
providing those fire protection services, the volunteer receives 47

any of the benefits provided in Chapter 146., 4121., or 4123. or 48
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 49
Code. 50

Sec. 1739.061. (A)(1) This section applies to both of the 51
following: 52

(a) A multiple employer welfare arrangement that issues or 53
requires the use of a standardized identification card or an 54
electronic technology for submission and routing of prescription 55
drug claims; 56

(b) A person or entity that a multiple employer welfare 57
arrangement contracts with to issue a standardized identification 58
card or an electronic technology described in division (A)(1)(a) 59
of this section. 60

(2) Notwithstanding division (A)(1) of this section, this 61
section does not apply to the issuance or required use of a 62
standardized identification card or an electronic technology for 63
the submission and routing of prescription drug claims in 64
connection with any of the following: 65

(a) Any program or arrangement covering only accident, 66
credit, dental, disability income, long-term care, hospital 67
indemnity, medicare supplement, medicare, tricare, specified 68
disease, or vision care; coverage under a 69
one-time-limited-duration policy ~~of not longer than~~ that is less than 70
~~six~~ twelve months; coverage issued as a supplement to liability 71
insurance; insurance arising out of workers' compensation or 72
similar law; automobile medical payment insurance; or insurance 73
under which benefits are payable with or without regard to fault 74
and which is statutorily required to be contained in any liability 75
insurance policy or equivalent self-insurance. 76

(b) Coverage provided under the medicaid program. 77

(c) Coverage provided under an employer's self-insurance plan 78
or by any of its administrators, as defined in section 3959.01 of 79
the Revised Code, to the extent that federal law supersedes, 80
preempts, prohibits, or otherwise precludes the application of 81
this section to the plan and its administrators. 82

(B) A standardized identification card or an electronic 83
technology issued or required to be used as provided in division 84
(A)(1) of this section shall contain uniform prescription drug 85
information in accordance with either division (B)(1) or (2) of 86
this section. 87

(1) The standardized identification card or the electronic 88
technology shall be in a format and contain information fields 89
approved by the national council for prescription drug programs or 90
a successor organization, as specified in the council's or 91
successor organization's pharmacy identification card 92
implementation guide in effect on the first day of October most 93
immediately preceding the issuance or required use of the 94
standardized identification card or the electronic technology. 95

(2) If the multiple employer welfare arrangement or person 96
under contract with it to issue a standardized identification card 97
or an electronic technology requires the information for the 98
submission and routing of a claim, the standardized identification 99
card or the electronic technology shall contain any of the 100
following information: 101

(a) The name of the multiple employer welfare arrangement; 102

(b) The individual's name, group number, and identification 103
number; 104

(c) A telephone number to inquire about pharmacy-related 105
issues; 106

(d) The issuer's international identification number, labeled 107
as "ANSI BIN" or "RxBIN"; 108

(e) The processor's control number, labeled as "RxPCN";	109
(f) The individual's pharmacy benefits group number if	110
different from the insured's medical group number, labeled as	111
"RxGrp."	112
(C) If the standardized identification card or the electronic	113
technology issued or required to be used as provided in division	114
(A)(1) of this section is also used for submission and routing of	115
nonpharmacy claims, the designation "Rx" is required to be	116
included as part of the labels identified in divisions (B)(2)(d)	117
and (e) of this section if the issuer's international	118
identification number or the processor's control number is	119
different for medical and pharmacy claims.	120
(D) Each multiple employer welfare arrangement described in	121
division (A) of this section shall annually file a certificate	122
with the superintendent of insurance certifying that it or any	123
person it contracts with to issue a standardized identification	124
card or electronic technology for submission and routing of	125
prescription drug claims complies with this section.	126
(E)(1) Except as provided in division (E)(2) of this section,	127
if there is a change in the information contained in the	128
standardized identification card or the electronic technology	129
issued to an individual, the multiple employer welfare arrangement	130
or person under contract with it to issue a standardized	131
identification card or an electronic technology shall issue a new	132
card or electronic technology to the individual.	133
(2) A multiple employer welfare arrangement or person under	134
contract with it is not required under division (E)(1) of this	135
section to issue a new card or electronic technology to an	136
individual more than once during a twelve-month period.	137
(F) Nothing in this section shall be construed as requiring a	138
multiple employer welfare arrangement to produce more than one	139

standardized identification card or one electronic technology for 140
use by individuals accessing health care benefits provided under a 141
multiple employer welfare arrangement. 142

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the 143
Revised Code, any policy, contract, or agreement for health care 144
services authorized by this chapter that is issued, delivered, or 145
renewed in this state and that provides that coverage of an 146
unmarried dependent child will terminate upon attainment of the 147
limiting age for dependent children specified in the policy, 148
contract, or agreement, shall also provide in substance both of 149
the following: 150

(1) Once an unmarried child has attained the limiting age for 151
dependent children, as provided in the policy, contract, or 152
agreement, upon the request of the subscriber, the health insuring 153
corporation shall offer to cover the unmarried child until the 154
child attains ~~twenty-eight~~ twenty-six years of age if all of the 155
following are true: 156

(a) The child is the natural child, stepchild, or adopted 157
child of the subscriber. 158

(b) The child is a resident of this state or a full-time 159
student at an accredited public or private institution of higher 160
education. 161

(c) The child is not employed by an employer that offers any 162
health benefit plan under which the child is eligible for 163
coverage. 164

(d) The child is not eligible for coverage under the medicaid 165
program or the medicare program. 166

(2) That attainment of the limiting age for dependent 167
children shall not operate to terminate the coverage of a 168
dependent child if the child is and continues to be both of the 169

following:	170
(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;	171 172
(b) Primarily dependent upon the subscriber for support and maintenance.	173 174
(B) Proof of incapacity and dependence for purposes of division (A)(2) of this section shall be furnished to the health insuring corporation within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency.	175 176 177 178 179 180 181
(C) Nothing in this section shall do any of the following:	182
(1) Require that any policy, contract, or agreement offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the policy, contract, or agreement;	183 184 185 186
(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the policy, contract, or agreement;	187 188 189 190
(3) Require an employer to offer health insurance coverage to the dependents of any employee.	191 192
(D) This section does not apply to any health insuring corporation policy, contract, or agreement offering only supplemental health care services or specialty health care services.	193 194 195 196
(E) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following:	197 198 199

(1) A public employee benefit plan;	200
(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.	201 202
Sec. 1751.69. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.	203 204 205 206 207 208
(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:	209 210 211 212 213 214 215 216
(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.	217 218 219 220 221
(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.	222 223 224 225
(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy,	226 227 228 229

contract, or agreement for orally administered cancer treatments 230
does not exceed one hundred dollars per prescription fill. The 231
cost sharing limit of one hundred dollars per prescription fill 232
shall apply to a high deductible plan, as defined in 26 U.S.C. 233
223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only 234
after the deductible has been met. 235

(D) The prohibitions in division (B) of this section do not 236
preclude an individual or group health insuring corporation 237
policy, contract, or agreement from requiring an enrollee to 238
obtain prior authorization before orally administered cancer 239
medication is dispensed to the enrollee. 240

(E) A health insuring corporation that offers coverage for 241
basic health care services is not required to comply with division 242
(B) of this section if all of the following apply: 243

(1) The health insuring corporation submits documentation 244
certified by an independent member of the American academy of 245
actuaries to the superintendent of insurance showing that 246
compliance with division (B)(1) of this section for a period of at 247
least six months independently caused the health insuring 248
corporation's costs for claims and administrative expenses for the 249
coverage of basic health care services to increase by more than 250
one per cent per year. 251

(2) The health insuring corporation submits a signed letter 252
from an independent member of the American academy of actuaries to 253
the superintendent of insurance opining that the increase in costs 254
described in division (E)(1) of this section could reasonably 255
justify an increase of more than one per cent in the annual 256
premiums or rates charged by the health insuring corporation for 257
the coverage of basic health care services. 258

(3)(a) The superintendent of insurance makes the following 259
determinations from the documentation and opinion submitted 260

pursuant to divisions (E)(1) and (2) of this section:	261
(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.	262 263 264 265 266
(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.	267 268 269 270
(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.	271 272 273
Sec. 3923.022. (A) As used in this section:	274
(1)(a) "Administrative expense" means the amount resulting from the following: the amount of premiums earned by the insurer for sickness and accident insurance business plus the amount of losses recovered from reinsurance coverage minus the sum of the amount of claims for losses paid; the amount of losses incurred but not reported; the amount incurred for state fees, federal and state taxes, and reinsurance; and the incurred costs and expenses related, either directly or indirectly, to the payment of commissions, measures to control fraud, and managed care.	275 276 277 278 279 280 281 282 283
(b) "Administrative expense" does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. "Amounts collected or administrative expenses incurred" means the total amount paid to an administrator for the administration and payment	284 285 286 287 288 289 290

of claims minus the sum of the amount of claims for losses paid 291
and the amount of losses incurred but not reported. 292

(2) "Insurer" means any insurance company authorized under 293
Title XXXIX of the Revised Code to do the business of sickness and 294
accident insurance in this state. 295

(3) "Sickness and accident insurance business" does not 296
include coverage provided by an insurer for specific diseases or 297
accidents only; any hospital indemnity, medicare supplement, 298
long-term care, disability income, one-time-limited-duration 299
policy ~~of no longer~~ that is less than six twelve months, or other 300
policy that offers only supplemental benefits; or coverage 301
provided to individuals who are not residents of this state. 302

(4) "Individual business" includes both individual sickness 303
and accident insurance and sickness and accident insurance made 304
available by insurers in the individual market to individuals, 305
with or without family members or dependents, through group 306
policies issued to one or more associations or entities. 307

(B) Notwithstanding section 3941.14 of the Revised Code, each 308
insurer shall have aggregate administrative expenses of no more 309
than twenty per cent of the premium income of the insurer, based 310
on the premiums earned in that year on the sickness and accident 311
insurance business of the insurer. 312

(C)(1) Each insurer, on the first day of January or within 313
sixty days thereafter, shall annually prepare, under oath, and 314
deposit in the office of the superintendent of insurance a 315
statement of the aggregate administrative expenses of the insurer, 316
based on the premiums earned in the immediately preceding calendar 317
year on the sickness and accident insurance business of the 318
insurer. The statement shall itemize and separately detail all of 319
the following information with respect to the insurer's sickness 320
and accident insurance business: 321

(a) The amount of premiums earned by the insurer both before and after any costs related to the insurer's purchase of reinsurance coverage;	322 323 324
(b) The total amount of claims for losses paid by the insurer both before and after any reimbursement from reinsurance coverage;	325 326
(c) The amount of any losses incurred by the insurer but not reported by the insurer in the current or prior year;	327 328
(d) The amount of costs incurred by the insurer for state fees and federal and state taxes;	329 330
(e) The amount of costs incurred by the insurer for reinsurance coverage;	331 332
(f) The amount of costs incurred by the insurer that are related to the insurer's payment of commissions;	333 334
(g) The amount of costs incurred by the insurer that are related to the insurer's fraud prevention measures;	335 336
(h) The amount of costs incurred by the insurer that are related to managed care; and	337 338
(i) Any other administrative expenses incurred by the insurer.	339 340
(2) The statement also shall include all of the information required under division (C)(1) of this section separately detailed for the insurer's individual business, small group business, and large group business.	341 342 343 344
(D) No insurer shall fail to comply with this section.	345
(E) If the superintendent determines that an insurer has violated this section, the superintendent, pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, may order the suspension of the insurer's license to do the business of sickness and accident insurance in this state until the superintendent is satisfied that the insurer is in	346 347 348 349 350 351

compliance with this section. If the insurer continues to do the 352
business of sickness and accident insurance in this state while 353
under the suspension order, the superintendent shall order the 354
insurer to pay one thousand dollars for each day of the violation. 355

(F) Any money collected by the superintendent under division 356
(E) of this section shall be deposited by the superintendent into 357
the state treasury to the credit of the department of insurance 358
operating fund. 359

(G) The statement of aggregate expenses filed pursuant to 360
this section separately detailing an insurer's individual, small 361
group, and large group business shall be considered work papers 362
resulting from the conduct of a market analysis of an entity 363
subject to examination by the superintendent under division (C) of 364
section 3901.48 of the Revised Code, except that the 365
superintendent may share aggregated market information that 366
identifies the premiums earned as reported under division 367
(C)(1)(a) of this section, the administrative expenses reported 368
under division (C)(1)(i) of this section, the amount of 369
commissions reported under division (C)(1)(f) of this section, the 370
amount of taxes paid as reported under division (C)(1)(d) of this 371
section, the total of the remaining benefit costs as reported 372
under divisions (C)(1)(b) and (c) of this section, and the amount 373
of fraud and managed care expenses reported under divisions 374
(C)(1)(g) and (h) of this section. 375

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the 376
Revised Code, every certificate furnished by an insurer in 377
connection with, or pursuant to any provision of, any group 378
sickness and accident insurance policy delivered, issued for 379
delivery, renewed, or used in this state on or after January 1, 380
1972, every policy of sickness and accident insurance delivered, 381
issued for delivery, renewed, or used in this state on or after 382

January 1, 1972, and every multiple employer welfare arrangement 383
offering an insurance program, which provides that coverage of an 384
unmarried dependent child of a parent or legal guardian will 385
terminate upon attainment of the limiting age for dependent 386
children specified in the contract shall also provide in substance 387
both of the following: 388

(1) Once an unmarried child has attained the limiting age for 389
dependent children, as provided in the policy, upon the request of 390
the insured, the insurer shall offer to cover the unmarried child 391
until the child attains ~~twenty-eight~~ twenty-six years of age if 392
all of the following are true: 393

(a) The child is the natural child, stepchild, or adopted 394
child of the insured. 395

(b) The child is a resident of this state or a full-time 396
student at an accredited public or private institution of higher 397
education. 398

(c) The child is not employed by an employer that offers any 399
health benefit plan under which the child is eligible for 400
coverage. 401

(d) The child is not eligible for the medicaid program or the 402
medicare program. 403

(2) That attainment of the limiting age for dependent 404
children shall not operate to terminate the coverage of a 405
dependent child if the child is and continues to be both of the 406
following: 407

(a) Incapable of self-sustaining employment by reason of 408
mental retardation or physical handicap; 409

(b) Primarily dependent upon the policyholder or certificate 410
holder for support and maintenance. 411

(B) Proof of such incapacity and dependence for purposes of 412

division (A)(2) of this section shall be furnished by the 413
policyholder or by the certificate holder to the insurer within 414
thirty-one days of the child's attainment of the limiting age. 415
Upon request, but not more frequently than annually after the 416
two-year period following the child's attainment of the limiting 417
age, the insurer may require proof satisfactory to it of the 418
continuance of such incapacity and dependency. 419

(C) Nothing in this section shall require an insurer to cover 420
a dependent child who is mentally retarded or physically 421
handicapped if the contract is underwritten on evidence of 422
insurability based on health factors set forth in the application, 423
or if such dependent child does not satisfy the conditions of the 424
contract as to any requirement for evidence of insurability or 425
other provision of the contract, satisfaction of which is required 426
for coverage thereunder to take effect. In any such case, the 427
terms of the contract shall apply with regard to the coverage or 428
exclusion of the dependent from such coverage. Nothing in this 429
section shall apply to accidental death or dismemberment benefits 430
provided by any such policy of sickness and accident insurance. 431

(D) Nothing in this section shall do any of the following: 432

(1) Require that any policy offer coverage for dependent 433
children or provide coverage for an unmarried dependent child's 434
children as dependents on the policy; 435

(2) Require an employer to pay for any part of the premium 436
for an unmarried dependent child that has attained the limiting 437
age for dependents, as provided in the policy; 438

(3) Require an employer to offer health insurance coverage to 439
the dependents of any employee. 440

(E) This section does not apply to any policies or 441
certificates covering only accident, credit, dental, disability 442
income, long-term care, hospital indemnity, medicare supplement, 443

specified disease, or vision care; coverage under a 444
one-time-limited-duration policy ~~of not longer~~ that is less than 445
~~six~~ twelve months; coverage issued as a supplement to liability 446
insurance; insurance arising out of a workers' compensation or 447
similar law; automobile medical-payment insurance; or insurance 448
under which benefits are payable with or without regard to fault 449
and that is statutorily required to be contained in any liability 450
insurance policy or equivalent self-insurance. 451

(F) As used in this section, "health benefit plan" has the 452
same meaning as in section 3924.01 of the Revised Code and also 453
includes both of the following: 454

(1) A public employee benefit plan; 455

(2) A health benefit plan as regulated under the "Employee 456
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 457

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the 458
Revised Code, any public employee benefit plan that provides that 459
coverage of an unmarried dependent child will terminate upon 460
attainment of the limiting age for dependent children specified in 461
the plan shall also provide in substance both of the following: 462

(1) Once an unmarried child has attained the limiting age for 463
dependent children, as provided in the plan, upon the request of 464
the employee, the public employee benefit plan shall offer to 465
cover the unmarried child until the child attains ~~twenty-eight~~ 466
twenty-six years of age if all of the following are true: 467

(a) The child is the natural child, stepchild, or adopted 468
child of the employee. 469

(b) The child is a resident of this state or a full-time 470
student at an accredited public or private institution of higher 471
education. 472

(c) The child is not employed by an employer that offers any 473

health benefit plan under which the child is eligible for 474
coverage. 475

(d) The child is not eligible for the medicaid program or the 476
medicare program. 477

(2) That attainment of the limiting age for dependent 478
children shall not operate to terminate the coverage of a 479
dependent child if the child is and continues to be both of the 480
following: 481

(a) Incapable of self-sustaining employment by reason of 482
mental retardation or physical handicap; 483

(b) Primarily dependent upon the plan member for support and 484
maintenance. 485

(B) Proof of incapacity and dependence for purposes of 486
division (A)(2) of this section shall be furnished to the public 487
employee benefit plan within thirty-one days of the child's 488
attainment of the limiting age. Upon request, but not more 489
frequently than annually, the public employee benefit plan may 490
require proof satisfactory to it of the continuance of such 491
incapacity and dependency. 492

(C) Nothing in this section shall do any of the following: 493

(1) Require that any public employee benefit plan offer 494
coverage for dependent children or provide coverage for an 495
unmarried dependent child's children as dependents on the public 496
employee benefit plan; 497

(2) Require an employer to pay for any part of the premium 498
for an unmarried dependent child that has attained the limiting 499
age for dependents, as provided in the plan; 500

(3) Require an employer to offer health insurance coverage to 501
the dependents of any employee. 502

(D) This section does not apply to any public employee 503

benefit plan covering only accident, credit, dental, disability 504
income, long-term care, hospital indemnity, medicare supplement, 505
specified disease, or vision care; coverage under a 506
one-time-limited-duration policy ~~of not longer~~ that is less than 507
~~six~~ twelve months; coverage issued as a supplement to liability 508
insurance; insurance arising out of a workers' compensation or 509
similar law; automobile medical-payment insurance; or insurance 510
under which benefits are payable with or without regard to fault 511
and which is statutorily required to be contained in any liability 512
insurance policy or equivalent self-insurance. 513

(E) As used in this section, "health benefit plan" has the 514
same meaning as in section 3924.01 of the Revised Code and also 515
includes both of the following: 516

(1) A public employee benefit plan; 517

(2) A health benefit plan as regulated under the "Employee 518
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 519

Sec. 3923.281. (A) As used in this section: 520

(1) "Biologically based mental illness" means schizophrenia, 521
schizoaffective disorder, major depressive disorder, bipolar 522
disorder, paranoia and other psychotic disorders, 523
obsessive-compulsive disorder, and panic disorder, as these terms 524
are defined in the most recent edition of the diagnostic and 525
statistical manual of mental disorders published by the American 526
psychiatric association. 527

(2) "Policy of sickness and accident insurance" has the same 528
meaning as in section 3923.01 of the Revised Code, but excludes 529
any hospital indemnity, medicare supplement, long-term care, 530
disability income, one-time-limited-duration policy ~~of not longer~~ 531
that is less than ~~six~~ twelve months, supplemental benefit, or 532
other policy that provides coverage for specific diseases or 533

accidents only; any policy that provides coverage for workers' 534
compensation claims compensable pursuant to Chapters 4121. and 535
4123. of the Revised Code; and any policy that provides coverage 536
to medicaid recipients. 537

(B) Notwithstanding section 3901.71 of the Revised Code, and 538
subject to division (E) of this section, every policy of sickness 539
and accident insurance shall provide benefits for the diagnosis 540
and treatment of biologically based mental illnesses on the same 541
terms and conditions as, and shall provide benefits no less 542
extensive than, those provided under the policy of sickness and 543
accident insurance for the treatment and diagnosis of all other 544
physical diseases and disorders, if both of the following apply: 545

(1) The biologically based mental illness is clinically 546
diagnosed by a physician authorized under Chapter 4731. of the 547
Revised Code to practice medicine and surgery or osteopathic 548
medicine and surgery; a psychologist licensed under Chapter 4732. 549
of the Revised Code; a professional clinical counselor, 550
professional counselor, or independent social worker licensed 551
under Chapter 4757. of the Revised Code; or a clinical nurse 552
specialist licensed under Chapter 4723. of the Revised Code whose 553
nursing specialty is mental health. 554

(2) The prescribed treatment is not experimental or 555
investigational, having proven its clinical effectiveness in 556
accordance with generally accepted medical standards. 557

(C) Division (B) of this section applies to all coverages and 558
terms and conditions of the policy of sickness and accident 559
insurance, including, but not limited to, coverage of inpatient 560
hospital services, outpatient services, and medication; maximum 561
lifetime benefits; copayments; and individual and family 562
deductibles. 563

(D) Nothing in this section shall be construed as prohibiting 564

a sickness and accident insurance company from taking any of the 565
following actions: 566

(1) Negotiating separately with mental health care providers 567
with regard to reimbursement rates and the delivery of health care 568
services; 569

(2) Offering policies that provide benefits solely for the 570
diagnosis and treatment of biologically based mental illnesses; 571

(3) Managing the provision of benefits for the diagnosis or 572
treatment of biologically based mental illnesses through the use 573
of pre-admission screening, by requiring beneficiaries to obtain 574
authorization prior to treatment, or through the use of any other 575
mechanism designed to limit coverage to that treatment determined 576
to be necessary; 577

(4) Enforcing the terms and conditions of a policy of 578
sickness and accident insurance. 579

(E) An insurer that offers any policy of sickness and 580
accident insurance is not required to provide benefits for the 581
diagnosis and treatment of biologically based mental illnesses 582
pursuant to division (B) of this section if all of the following 583
apply: 584

(1) The insurer submits documentation certified by an 585
independent member of the American academy of actuaries to the 586
superintendent of insurance showing that incurred claims for 587
diagnostic and treatment services for biologically based mental 588
illnesses for a period of at least six months independently caused 589
the insurer's costs for claims and administrative expenses for the 590
coverage of all other physical diseases and disorders to increase 591
by more than one per cent per year. 592

(2) The insurer submits a signed letter from an independent 593
member of the American academy of actuaries to the superintendent 594
of insurance opining that the increase described in division 595

(E)(1) of this section could reasonably justify an increase of 596
more than one per cent in the annual premiums or rates charged by 597
the insurer for the coverage of all other physical diseases and 598
disorders. 599

(3) The superintendent of insurance makes the following 600
determinations from the documentation and opinion submitted 601
pursuant to divisions (E)(1) and (2) of this section: 602

(a) Incurred claims for diagnostic and treatment services for 603
biologically based mental illnesses for a period of at least six 604
months independently caused the insurer's costs for claims and 605
administrative expenses for the coverage of all other physical 606
diseases and disorders to increase by more than one per cent per 607
year. 608

(b) The increase in costs reasonably justifies an increase of 609
more than one per cent in the annual premiums or rates charged by 610
the insurer for the coverage of all other physical diseases and 611
disorders. 612

Any determination made by the superintendent under this 613
division is subject to Chapter 119. of the Revised Code. 614

Sec. 3923.57. Notwithstanding any provision of this chapter, 615
every individual policy of sickness and accident insurance that is 616
delivered, issued for delivery, or renewed in this state is 617
subject to the following conditions, as applicable: 618

(A) Pre-existing conditions provisions shall not exclude or 619
limit coverage for a period beyond twelve months following the 620
policyholder's effective date of coverage and may only relate to 621
conditions during the six months immediately preceding the 622
effective date of coverage. 623

(B) In determining whether a pre-existing conditions 624
provision applies to a policyholder or dependent, each policy 625

shall credit the time the policyholder or dependent was covered 626
under a previous policy, contract, or plan if the previous 627
coverage was continuous to a date not more than thirty days prior 628
to the effective date of the new coverage, exclusive of any 629
applicable service waiting period under the policy. 630

(C)(1) Except as otherwise provided in division (C) of this 631
section, an insurer that provides an individual sickness and 632
accident insurance policy to an individual shall renew or continue 633
in force such coverage at the option of the individual. 634

(2) An insurer may nonrenew or discontinue coverage of an 635
individual in the individual market based only on one or more of 636
the following reasons: 637

(a) The individual failed to pay premiums or contributions in 638
accordance with the terms of the policy or the insurer has not 639
received timely premium payments. 640

(b) The individual performed an act or practice that 641
constitutes fraud or made an intentional misrepresentation of 642
material fact under the terms of the policy. 643

(c) The insurer is ceasing to offer coverage in the 644
individual market in accordance with division (D) of this section 645
and the applicable laws of this state. 646

(d) If the insurer offers coverage in the market through a 647
network plan, the individual no longer resides, lives, or works in 648
the service area, or in an area for which the insurer is 649
authorized to do business; provided, however, that such coverage 650
is terminated uniformly without regard to any health 651
status-related factor of covered individuals. 652

(e) If the coverage is made available in the individual 653
market only through one or more bona fide associations, the 654
membership of the individual in the association, on the basis of 655
which the coverage is provided, ceases; provided, however, that 656

such coverage is terminated under division (C)(2)(e) of this 657
section uniformly without regard to any health status-related 658
factor of covered individuals. 659

An insurer offering coverage to individuals solely through 660
membership in a bona fide association shall not be deemed, by 661
virtue of that offering, to be in the individual market for 662
purposes of sections 3923.58 and 3923.581 of the Revised Code. 663
Such an insurer shall not be required to accept applicants for 664
coverage in the individual market pursuant to sections 3923.58 and 665
3923.581 of the Revised Code unless the insurer also offers 666
coverage to individuals other than through bona fide associations. 667

(3) An insurer may cancel or decide not to renew the coverage 668
of a dependent of an individual if the dependent has performed an 669
act or practice that constitutes fraud or made an intentional 670
misrepresentation of material fact under the terms of the coverage 671
and if the cancellation or nonrenewal is not based, either 672
directly or indirectly, on any health status-related factor in 673
relation to the dependent. 674

(D)(1) If an insurer decides to discontinue offering a 675
particular type of health insurance coverage offered in the 676
individual market, coverage of such type may be discontinued by 677
the insurer if the insurer does all of the following: 678

(a) Provides notice to each individual provided coverage of 679
this type in such market of the discontinuation at least ninety 680
days prior to the date of the discontinuation of the coverage; 681

(b) Offers to each individual provided coverage of this type 682
in such market, the option to purchase any other individual health 683
insurance coverage currently being offered by the insurer for 684
individuals in that market; 685

(c) In exercising the option to discontinue coverage of this 686
type and in offering the option of coverage under division 687

(D)(1)(b) of this section, acts uniformly without regard to any 688
health status-related factor of covered individuals or of 689
individuals who may become eligible for such coverage. 690

(2) If an insurer elects to discontinue offering all health 691
insurance coverage in the individual market in this state, health 692
insurance coverage may be discontinued by the insurer only if both 693
of the following apply: 694

(a) The insurer provides notice to the department of 695
insurance and to each individual of the discontinuation at least 696
one hundred eighty days prior to the date of the expiration of the 697
coverage. 698

(b) All health insurance delivered or issued for delivery in 699
this state in such market is discontinued and coverage under that 700
health insurance in that market is not renewed. 701

(3) In the event of a discontinuation under division (D)(2) 702
of this section in the individual market, the insurer shall not 703
provide for the issuance of any health insurance coverage in the 704
market and this state during the five-year period beginning on the 705
date of the discontinuation of the last health insurance coverage 706
not so renewed. 707

(E) Notwithstanding divisions (C) and (D) of this section, an 708
insurer may, at the time of coverage renewal, modify the health 709
insurance coverage for a policy form offered to individuals in the 710
individual market if the modification is consistent with the law 711
of this state and effective on a uniform basis among all 712
individuals with that policy form. 713

(F) Such policies are subject to sections 2743 and 2747 of 714
the "Health Insurance Portability and Accountability Act of 1996," 715
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 716
300gg-47, as amended. 717

(G) Sections 3924.031 and 3924.032 of the Revised Code shall 718

apply to sickness and accident insurance policies offered in the 719
individual market in the same manner as they apply to health 720
benefit plans offered in the small employer market. 721

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of 722
this section also apply to all group sickness and accident 723
insurance policies that are not sold in connection with an 724
employment-related group health plan and that provide more than 725
short-term, limited duration coverage. 726

In applying divisions (C) to (G) of this section with respect 727
to health insurance coverage that is made available by an insurer 728
in the individual market to individuals only through one or more 729
associations, the term "individual" includes the association of 730
which the individual is a member. 731

For purposes of this section, any policy issued pursuant to 732
division (C) of section 3923.13 of the Revised Code in connection 733
with a public or private college or university student health 734
insurance program is considered to be issued to a bona fide 735
association. 736

As used in this section, "bona fide association" has the same 737
meaning as in section 3924.03 of the Revised Code, and "health 738
status-related factor" and "network plan" have the same meanings 739
as in section 3924.031 of the Revised Code. 740

This section does not apply to any policy that provides 741
coverage for specific diseases or accidents only, or to any 742
hospital indemnity, medicare supplement, long-term care, 743
disability income, one-time-limited-duration policy ~~of no longer~~ 744
that is less than six twelve months, or other policy that offers 745
only supplemental benefits. 746

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 747
the Revised Code: 748

(1) "Base rate" means, as to any health benefit plan that is 749
issued by a carrier in the individual market, the lowest premium 750
rate for new or existing business prescribed by the carrier for 751
the same or similar coverage under a plan or arrangement covering 752
any individual with similar case characteristics. 753

(2) "Carrier," "health benefit plan," and "MEWA" have the 754
same meanings as in section 3924.01 of the Revised Code. 755

(3) "Network plan" means a health benefit plan of a carrier 756
under which the financing and delivery of medical care, including 757
items and services paid for as medical care, are provided, in 758
whole or in part, through a defined set of providers under 759
contract with the carrier. 760

(4) "Ohio health care basic and standard plans" means those 761
plans established under section 3924.10 of the Revised Code. 762

(5) "Pre-existing conditions provision" means a policy 763
provision that excludes or limits coverage for charges or expenses 764
incurred during a specified period following the insured's 765
effective date of coverage as to a condition which, during a 766
specified period immediately preceding the effective date of 767
coverage, had manifested itself in such a manner as would cause an 768
ordinarily prudent person to seek medical advice, diagnosis, care, 769
or treatment or for which medical advice, diagnosis, care, or 770
treatment was recommended or received, or a pregnancy existing on 771
the effective date of coverage. 772

(B) Beginning in January of each year, carriers in the 773
business of issuing health benefit plans to individuals and 774
nonemployer groups, except individual health benefit plans issued 775
pursuant to sections 1751.16 and 3923.122 of the Revised Code, 776
shall accept applicants for open enrollment coverage, as set forth 777
in this division, in the order in which they apply for coverage 778
and subject to the limitation set forth in division (G) of this 779

section. Carriers shall accept for coverage pursuant to this 780
section individuals to whom both of the following conditions 781
apply: 782

(1) The individual is not applying for coverage as an 783
employee of an employer, as a member of an association, or as a 784
member of any other group. 785

(2) The individual is not covered, and is not eligible for 786
coverage, under any other private or public health benefits 787
arrangement, including the medicare program established under 788
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 789
U.S.C.A. 301, as amended, or any other act of congress or law of 790
this or any other state of the United States that provides 791
benefits comparable to the benefits provided under this section, 792
any medicare supplement policy, or any continuation of coverage 793
policy under state or federal law. 794

(C) A carrier shall offer to any individual accepted under 795
this section the Ohio health care basic and standard plans or 796
health benefit plans that are substantially similar to the Ohio 797
health care basic and standard plans in benefit plan design and 798
scope of covered services. 799

A carrier may offer other health benefit plans in addition 800
to, but not in lieu of, the plans required to be offered under 801
this division. A basic health benefit plan shall provide, at a 802
minimum, the coverage provided by the Ohio health care basic plan 803
or any health benefit plan that is substantially similar to the 804
Ohio health care basic plan in benefit plan design and scope of 805
covered services. A standard health benefit plan shall provide, at 806
a minimum, the coverage provided by the Ohio health care standard 807
plan or any health benefit plan that is substantially similar to 808
the Ohio health care standard plan in benefit plan design and 809
scope of covered services. 810

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

(D)(1) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. A health insuring corporation may apply a pre-existing condition provision for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section except with respect to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(2) In determining whether a pre-existing conditions provision applies to an insured or dependent, each policy shall credit the time the insured or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy.

(E) Premiums charged to individuals under this section may not exceed the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate for coverage

offered to any other individual to which the carrier is currently 842
accepting new business and for which similar copayments and 843
deductibles are applied, unless the superintendent of insurance 844
determines that the amendments by this act to this section and 845
section 3923.581 of the Revised Code, have resulted in the 846
market-wide average medical loss ratio for coverage sold to 847
individual insureds and nonemployer group insureds in this state, 848
including open enrollment insureds, to increase by more than five 849
and one quarter percentage points during calendar year 2010. If 850
the superintendent makes that determination, the premium limit 851
established by division (E)(1) of this section shall remain in 852
effect. The superintendent's determination shall be supported by a 853
signed letter from a member of the American academy of actuaries. 854

(F) In offering health benefit plans under this section, a 855
carrier may require the purchase of health benefit plans that 856
condition the reimbursement of health services upon the use of a 857
specific network of providers. 858

(G)(1) A carrier shall not be required to accept new 859
applicants under this section if the total number of the carrier's 860
current insureds with open enrollment coverage issued under this 861
section calculated as of the immediately preceding thirty-first 862
day of December and excluding the carrier's medicare supplement 863
policies and conversion or continuation of coverage policies under 864
state or federal law and any policies described in division (L) of 865
this section meets the following limits: 866

(a) For calendar years 2010 and 2011, four per cent of the 867
carrier's total number of individual or nonemployer group insureds 868
in this state; 869

(b) For calendar year 2012 and every year thereafter, eight 870
per cent of the carrier's total number of insured individuals and 871
nonemployer group insureds in this state, unless the 872
superintendent of insurance determines that the amendments by this 873

act to this section and section 3923.581 of the Revised Code, have 874
resulted in the market-wide average medical loss ratio for 875
coverage sold to individual insureds and nonemployer group 876
insureds in this state, including open enrollment insureds, to 877
increase by more than five and one quarter percentage points 878
during calendar year 2010. If the superintendent makes that 879
determination, the enrollment limit established by division 880
(G)(1)(a) of this section shall remain in effect. The 881
superintendent's determination shall be supported by a signed 882
letter from a member of the American academy of actuaries. 883

(2) An officer of the carrier shall certify to the department 884
of insurance when it has met the enrollment limit set forth in 885
division (G)(1) of this section. Upon providing such 886
certification, the carrier shall be relieved of its open 887
enrollment requirement under this section as long as the carrier 888
continues to meet the open enrollment limit. If the total number 889
of the carrier's current insureds with open enrollment coverage 890
issued under this section falls below the enrollment limit, the 891
carrier shall accept new applicants. A carrier may establish a 892
waiting list if the carrier has met the open enrollment limit and 893
shall notify the superintendent if the carrier has a waiting list 894
in effect. 895

(H) A carrier shall not be required to accept under this 896
section applicants who, at the time of enrollment, are confined to 897
a health care facility because of chronic illness, permanent 898
injury, or other infirmity that would cause economic impairment to 899
the carrier if the applicants were accepted. A carrier shall not 900
be required to make the effective date of benefits for individuals 901
accepted under this section earlier than ninety days after the 902
date of acceptance, except that when the individual had prior 903
coverage with a health benefit plan that was terminated by a 904
carrier because the carrier exited the market and the individual 905

was accepted for open enrollment under this section within 906
sixty-three days of that termination, the effective date of 907
benefits shall be the date of enrollment. 908

(I) The requirements of this section do not apply to any 909
carrier that is currently in a state of supervision, insolvency, 910
or liquidation. If a carrier demonstrates to the satisfaction of 911
the superintendent that the requirements of this section would 912
place the carrier in a state of supervision, insolvency, or 913
liquidation, or would otherwise jeopardize the carrier's economic 914
viability overall or in the individual market, the superintendent 915
may waive or modify the requirements of division (B) or (G) of 916
this section. The actions of the superintendent under this 917
division shall be effective for a period of not more than one 918
year. At the expiration of such time, a new showing of need for a 919
waiver or modification by the carrier shall be made before a new 920
waiver or modification is issued or imposed. 921

(J) No hospital, health care facility, or health care 922
practitioner, and no person who employs any health care 923
practitioner, shall balance bill any individual or dependent of an 924
individual for any health care supplies or services provided to 925
the individual or dependent who is insured under a policy issued 926
under this section. The hospital, health care facility, or health 927
care practitioner, or any person that employs the health care 928
practitioner, shall accept payments made to it by the carrier 929
under the terms of the policy or contract insuring or covering 930
such individual as payment in full for such health care supplies 931
or services. 932

As used in this division, "hospital" has the same meaning as 933
in section 3727.01 of the Revised Code; "health care practitioner" 934
has the same meaning as in section 4769.01 of the Revised Code; 935
and "balance bill" means charging or collecting an amount in 936
excess of the amount reimbursable or payable under the policy or 937

health care service contract issued to an individual under this 938
section for such health care supply or service. "Balance bill" 939
does not include charging for or collecting copayments or 940
deductibles required by the policy or contract. 941

(K) A carrier may pay an agent a commission in the amount of 942
not more than five per cent of the premium charged for initial 943
placement or for otherwise securing the issuance of a policy or 944
contract issued to an individual under this section, and not more 945
than four per cent of the premium charged for the renewal of such 946
a policy or contract. The superintendent may adopt, in accordance 947
with Chapter 119. of the Revised Code, such rules as are necessary 948
to enforce this division. 949

(L) This section does not apply to any policy that provides 950
coverage for specific diseases or accidents only, or to any 951
hospital indemnity, medicare supplement, long-term care, 952
disability income, one-time-limited-duration policy ~~of no longer~~ 953
that is less than six twelve months, or other policy that offers 954
only supplemental benefits. 955

(M) If a carrier offers a health benefit plan in the 956
individual market through a network plan, the carrier may do both 957
of the following: 958

(1) Limit the individuals that may apply for such coverage to 959
those who live, work, or reside in the service area of the network 960
plan; 961

(2) Within the service area of the network plan, deny the 962
coverage to individuals if the carrier has demonstrated both of 963
the following to the superintendent: 964

(a) The carrier will not have the capacity to deliver 965
services adequately to any additional individuals because of the 966
carrier's obligations to existing group contract holders and 967
individuals. 968

(b) The carrier is applying division (M)(2) of this section 969
uniformly to all individuals without regard to any health 970
status-related factors of those individuals. 971

(N) A carrier that, pursuant to division (M)(2) of this 972
section, denies coverage to an individual in the service area of a 973
network plan, shall not offer coverage in the individual market 974
within that service area for at least one hundred eighty days 975
after the date the carrier denies the coverage. 976

Sec. 3923.601. (A)(1) This section applies to both of the 977
following: 978

(a) A sickness and accident insurer that issues or requires 979
the use of a standardized identification card or an electronic 980
technology for submission and routing of prescription drug claims 981
pursuant to a policy, contract, or agreement for health care 982
services; 983

(b) A person that a sickness and accident insurer contracts 984
with to issue a standardized identification card or an electronic 985
technology described in division (A)(1)(a) of this section. 986

(2) Notwithstanding division (A)(1) of this section, this 987
section does not apply to the issuance or required use of a 988
standardized identification card or an electronic technology for 989
the submission and routing of prescription drug claims in 990
connection with any of the following: 991

(a) Any individual or group policy of sickness and accident 992
insurance covering only accident, credit, dental, disability 993
income, long-term care, hospital indemnity, medicare supplement, 994
medicare, tricare, specified disease, or vision care; coverage 995
under a one-time-limited-duration policy of not longer than is 996
less than six twelve months; coverage issued as a supplement to 997
liability insurance; insurance arising out of workers' 998

compensation or similar law; automobile medical payment insurance;	999
or insurance under which benefits are payable with or without	1000
regard to fault and which is statutorily required to be contained	1001
in any liability insurance policy or equivalent self-insurance.	1002
(b) Coverage provided under the medicaid program.	1003
(c) Coverage provided under an employer's self-insurance plan	1004
or by any of its administrators, as defined in section 3959.01 of	1005
the Revised Code, to the extent that federal law supersedes,	1006
preempts, prohibits, or otherwise precludes the application of	1007
this section to the plan and its administrators.	1008
(B) A standardized identification card or an electronic	1009
technology issued or required to be used as provided in division	1010
(A)(1) of this section shall contain uniform prescription drug	1011
information in accordance with either division (B)(1) or (2) of	1012
this section.	1013
(1) The standardized identification card or the electronic	1014
technology shall be in a format and contain information fields	1015
approved by the national council for prescription drug programs or	1016
a successor organization, as specified in the council's or	1017
successor organization's pharmacy identification card	1018
implementation guide in effect on the first day of October most	1019
immediately preceding the issuance or required use of the	1020
standardized identification card or the electronic technology.	1021
(2) If the insurer or person under contract with the insurer	1022
to issue a standardized identification card or an electronic	1023
technology requires the information for the submission and routing	1024
of a claim, the standardized identification card or the electronic	1025
technology shall contain any of the following information:	1026
(a) The insurer's name;	1027
(b) The insured's name, group number, and identification	1028
number;	1029

(c) A telephone number to inquire about pharmacy-related issues;	1030 1031
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	1032 1033
(e) The processor's control number, labeled as "RxPCN";	1034
(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."	1035 1036
(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.	1037 1038 1039 1040 1041 1042 1043 1044
(D) Each sickness and accident insurer described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section.	1045 1046 1047 1048 1049 1050
(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the insured.	1051 1052 1053 1054 1055 1056 1057
(2) An insurer or person under contract with the insurer is not required under division (E)(1) of this section to issue a new card or electronic technology to an insured more than once during	1058 1059 1060

a twelve-month period. 1061

(F) Nothing in this section shall be construed as requiring 1062
an insurer to produce more than one standardized identification 1063
card or one electronic technology for use by insureds accessing 1064
health care benefits provided under a policy of sickness and 1065
accident insurance. 1066

Sec. 3923.65. (A) As used in this section: 1067

(1) "Emergency medical condition" means a medical condition 1068
that manifests itself by such acute symptoms of sufficient 1069
severity, including severe pain, that a prudent layperson with 1070
average knowledge of health and medicine could reasonably expect 1071
the absence of immediate medical attention to result in any of the 1072
following: 1073

(a) Placing the health of the individual or, with respect to 1074
a pregnant woman, the health of the woman or her unborn child, in 1075
serious jeopardy; 1076

(b) Serious impairment to bodily functions; 1077

(c) Serious dysfunction of any bodily organ or part. 1078

(2) "Emergency services" means the following: 1079

(a) A medical screening examination, as required by federal 1080
law, that is within the capability of the emergency department of 1081
a hospital, including ancillary services routinely available to 1082
the emergency department, to evaluate an emergency medical 1083
condition; 1084

(b) Such further medical examination and treatment that are 1085
required by federal law to stabilize an emergency medical 1086
condition and are within the capabilities of the staff and 1087
facilities available at the hospital, including any trauma and 1088
burn center of the hospital. 1089

(B) Every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services.

(C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy shall provide information regarding the following:

(1) The scope of coverage for emergency services;

(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;

(3) Any copayments for emergency services.

(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited duration policy ~~of no longer~~ that is less than six twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Sec. 3923.83. (A)(1) This section applies to both of the following:

(a) A public employee benefit plan that issues or requires 1120
the use of a standardized identification card or an electronic 1121
technology for submission and routing of prescription drug claims 1122
pursuant to a policy, contract, or agreement for health care 1123
services; 1124

(b) A person or entity that a public employee benefit plan 1125
contracts with to issue a standardized identification card or an 1126
electronic technology described in division (A)(1)(a) of this 1127
section. 1128

(2) Notwithstanding division (A)(1) of this section, this 1129
section does not apply to the issuance or required use of a 1130
standardized identification card or an electronic technology for 1131
the submission and routing of prescription drug claims in 1132
connection with either of the following: 1133

(a) Any individual or group policy of insurance covering only 1134
accident, credit, dental, disability income, long-term care, 1135
hospital indemnity, medicare supplement, medicare, tricare, 1136
specified disease, or vision care; coverage under a 1137
one-time-limited-duration policy ~~of not longer~~ that is less than 1138
~~six~~ twelve months; coverage issued as a supplement to liability 1139
insurance; insurance arising out of workers' compensation or 1140
similar law; automobile medical payment insurance; or insurance 1141
under which benefits are payable with or without regard to fault 1142
and which is statutorily required to be contained in any liability 1143
insurance policy or equivalent self-insurance. 1144

(b) Coverage provided under the medicaid program. 1145

(B) A standardized identification card or an electronic 1146
technology issued or required to be used as provided in division 1147
(A)(1) of this section shall contain uniform prescription drug 1148
information in accordance with either division (B)(1) or (2) of 1149
this section. 1150

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the public employee benefit plan or person under contract with the plan to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The plan's name;

(b) The insured's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international

identification number or the processor's control number is 1181
different for medical and pharmacy claims. 1182

(D)(1) Except as provided in division (D)(2) of this section, 1183
if there is a change in the information contained in the 1184
standardized identification card or the electronic technology 1185
issued to an insured, the public employee benefit plan or person 1186
under contract with the plan to issue a standardized 1187
identification card or electronic technology shall issue a new 1188
card or electronic technology to the insured. 1189

(2) A public employee benefit plan or person under contract 1190
with the plan is not required under division (D)(1) of this 1191
section to issue a new card or electronic technology to an insured 1192
more than once during a twelve-month period. 1193

(E) Nothing in this section shall be construed as requiring a 1194
public employee benefit plan to produce more than one standardized 1195
identification card or one electronic technology for use by 1196
insureds accessing health care benefits provided under a health 1197
benefit plan. 1198

Sec. 3923.85. (A) As used in this section, "cost sharing" 1199
means the cost to an individual insured under an individual or 1200
group policy of sickness and accident insurance or a public 1201
employee benefit plan according to any coverage limit, copayment, 1202
coinsurance, deductible, or other out-of-pocket expense 1203
requirements imposed by the policy or plan. 1204

(B) Notwithstanding section 3901.71 of the Revised Code and 1205
subject to division (D) of this section, no individual or group 1206
policy of sickness and accident insurance that is delivered, 1207
issued for delivery, or renewed in this state and no public 1208
employee benefit plan that is established or modified in this 1209
state shall fail to comply with either of the following: 1210

(1) The policy or plan shall not provide coverage or impose 1211
cost sharing for a prescribed, orally administered cancer 1212
medication on a less favorable basis than the coverage it provides 1213
or cost sharing it imposes for intravenously administered or 1214
injected cancer medications. 1215

(2) The policy or plan shall not comply with division (B)(1) 1216
of this section by imposing an increase in cost sharing solely for 1217
orally administered, intravenously administered, or injected 1218
cancer medications. 1219

(C) Notwithstanding any provision of this section to the 1220
contrary, a policy or plan shall be deemed to be in compliance 1221
with this section if the cost sharing imposed under such a policy 1222
or plan for orally administered cancer treatments does not exceed 1223
one hundred dollars per prescription fill. The cost sharing limit 1224
of one hundred dollars per prescription fill shall apply to a high 1225
deductible plan, as defined in 26 U.S.C. 223, or a catastrophic 1226
plan, as defined in 42 U.S.C. 18022, only after the deductible has 1227
been met. 1228

(D)(1) The prohibitions in division (B) of this section do 1229
not preclude an individual or group policy of sickness and 1230
accident insurance or public employee benefit plan from requiring 1231
an insured or plan member to obtain prior authorization before 1232
orally administered cancer medication is dispensed to the insured 1233
or plan member. 1234

(2) Division (B) of this section does not apply to the offer 1235
or renewal of any individual or group policy of sickness and 1236
accident insurance that provides coverage for specific diseases or 1237
accidents only, or to any hospital indemnity, medicare supplement, 1238
disability income, or other policy that offers only supplemental 1239
benefits. 1240

(E) An insurer that offers any sickness and accident 1241

insurance or any public employee benefit plan that offers coverage 1242
for basic health care services is not required to comply with 1243
division (B) of this section if all of the following apply: 1244

(1) The insurer or plan submits documentation certified by an 1245
independent member of the American academy of actuaries to the 1246
superintendent of insurance showing that compliance with division 1247
(B)(1) of this section for a period of at least six months 1248
independently caused the insurer or plan's costs for claims and 1249
administrative expenses for the coverage of basic health care 1250
services to increase by more than one per cent per year. 1251

(2) The insurer or plan submits a signed letter from an 1252
independent member of the American academy of actuaries to the 1253
superintendent of insurance opining that the increase in costs 1254
described in division (E)(1) of this section could reasonably 1255
justify an increase of more than one per cent in the annual 1256
premiums or rates charged by the insurer or plan for the coverage 1257
of basic health care services. 1258

(3)(a) The superintendent of insurance makes the following 1259
determinations from the documentation and opinion submitted 1260
pursuant to divisions (E)(1) and (2) of this section: 1261

(i) Compliance with division (B)(1) of this section for a 1262
period of at least six months independently caused the insurer or 1263
plan's costs for claims and administrative expenses for the 1264
coverage of basic health care services to increase more than one 1265
per cent per year. 1266

(ii) The increase in costs reasonably justifies an increase 1267
of more than one per cent in the annual premiums or rates charged 1268
by the insurer or plan for the coverage of basic health care 1269
services. 1270

(b) Any determination made by the superintendent under 1271
division (E)(3) of this section is subject to Chapter 119. of the 1272

Revised Code. 1273

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the 1274
Revised Code: 1275

(A) "Actuarial certification" means a written statement 1276
prepared by a member of the American academy of actuaries, or by 1277
any other person acceptable to the superintendent of insurance, 1278
that states that, based upon the person's examination, a carrier 1279
offering health benefit plans to small employers is in compliance 1280
with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial 1281
certification" shall include a review of the appropriate records 1282
of, and the actuarial assumptions and methods used by, the carrier 1283
relative to establishing premium rates for the health benefit 1284
plans. 1285

(B) "Adjusted average market premium price" means the average 1286
market premium price as determined by the board of directors of 1287
the Ohio health reinsurance program either on the basis of the 1288
arithmetic mean of all carriers' premium rates for an OHC plan 1289
sold to groups with similar case characteristics by all carriers 1290
selling OHC plans in the state, or on any other equitable basis 1291
determined by the board. 1292

(C) "Base premium rate" means, as to any health benefit plan 1293
that is issued by a carrier and that covers at least two but no 1294
more than fifty employees of a small employer, the lowest premium 1295
rate for a new or existing business prescribed by the carrier for 1296
the same or similar coverage under a plan or arrangement covering 1297
any small employer with similar case characteristics. 1298

(D) "Carrier" means any sickness and accident insurance 1299
company or health insuring corporation authorized to issue health 1300
benefit plans in this state or a MEWA. A sickness and accident 1301
insurance company that owns or operates a health insuring 1302
corporation, either as a separate corporation or as a line of 1303

business, shall be considered as a separate carrier from that 1304
health insuring corporation for purposes of sections 3924.01 to 1305
3924.14 of the Revised Code. 1306

(E) "Case characteristics" means, with respect to a small 1307
employer, the geographic area in which the employees work; the age 1308
and sex of the individual employees and their dependents; the 1309
appropriate industry classification as determined by the carrier; 1310
the number of employees and dependents; and such other objective 1311
criteria as may be established by the carrier. "Case 1312
characteristics" does not include claims experience, health 1313
status, or duration of coverage from the date of issue. 1314

(F) "Dependent" means the spouse or child of an eligible 1315
employee, subject to applicable terms of the health benefits plan 1316
covering the employee. 1317

(G) "Eligible employee" means an employee who works a normal 1318
work week of ~~twenty-five~~ thirty or more hours. "Eligible employee" 1319
does not include a temporary or substitute employee, or a seasonal 1320
employee who works only part of the calendar year on the basis of 1321
natural or suitable times or circumstances. 1322

(H) "Health benefit plan" means any hospital or medical 1323
expense policy or certificate or any health plan provided by a 1324
carrier, that is delivered, issued for delivery, renewed, or used 1325
in this state on or after the date occurring six months after 1326
November 24, 1995. "Health benefit plan" does not include policies 1327
covering only accident, credit, dental, disability income, 1328
long-term care, hospital indemnity, medicare supplement, specified 1329
disease, or vision care; coverage under a 1330
one-time-limited-duration policy ~~of no longer~~ that is less than 1331
~~six~~ twelve months; coverage issued as a supplement to liability 1332
insurance; insurance arising out of a workers' compensation or 1333
similar law; automobile medical-payment insurance; or insurance 1334
under which benefits are payable with or without regard to fault 1335

and which is statutorily required to be contained in any liability 1336
insurance policy or equivalent self-insurance. 1337

(I) "Late enrollee" means an eligible employee or dependent 1338
who enrolls in a small employer's health benefit plan other than 1339
during the first period in which the employee or dependent is 1340
eligible to enroll under the plan or during a special enrollment 1341
period described in section 2701(f) of the "Health Insurance 1342
Portability and Accountability Act of 1996," Pub. L. No. 104-191, 1343
110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 1344

(J) "MEWA" means any "multiple employer welfare arrangement" 1345
as defined in section 3 of the "Federal Employee Retirement Income 1346
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 1347
except for any arrangement which is fully insured as defined in 1348
division (b)(6)(D) of section 514 of that act. 1349

(K) "Midpoint rate" means, for small employers with similar 1350
case characteristics and plan designs and as determined by the 1351
applicable carrier for a rating period, the arithmetic average of 1352
the applicable base premium rate and the corresponding highest 1353
premium rate. 1354

(L) "Pre-existing conditions provision" means a policy 1355
provision that excludes or limits coverage for charges or expenses 1356
incurred during a specified period following the insured's 1357
enrollment date as to a condition for which medical advice, 1358
diagnosis, care, or treatment was recommended or received during a 1359
specified period immediately preceding the enrollment date. 1360
Genetic information shall not be treated as such a condition in 1361
the absence of a diagnosis of the condition related to such 1362
information. 1363

For purposes of this division, "enrollment date" means, with 1364
respect to an individual covered under a group health benefit 1365
plan, the date of enrollment of the individual in the plan or, if 1366

earlier, the first day of the waiting period for such enrollment. 1367

(M) "Service waiting period" means the period of time after 1368
employment begins before an employee is eligible to be covered for 1369
benefits under the terms of any applicable health benefit plan 1370
offered by the small employer. 1371

(N)(1) "Small employer" means, in connection with a group 1372
health benefit plan and with respect to a calendar year and a plan 1373
year, an employer who employed an average of at least two but no 1374
more than fifty eligible employees on business days during the 1375
preceding calendar year and who employs at least two employees on 1376
the first day of the plan year. 1377

(2) For purposes of division (N)(1) of this section, all 1378
persons treated as a single employer under subsection (b), (c), 1379
(m), or (o) of section 414 of the "Internal Revenue Code of 1986," 1380
100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one 1381
employer. In the case of an employer that was not in existence 1382
throughout the preceding calendar year, the determination of 1383
whether the employer is a small or large employer shall be based 1384
on the average number of eligible employees that it is reasonably 1385
expected the employer will employ on business days in the current 1386
calendar year. Any reference in division (N) of this section to an 1387
"employer" includes any predecessor of the employer. Except as 1388
otherwise specifically provided, provisions of sections 3924.01 to 1389
3924.14 of the Revised Code that apply to a small employer that 1390
has a health benefit plan shall continue to apply until the plan 1391
anniversary following the date the employer no longer meets the 1392
requirements of this division. 1393

(O) "OHC plan" means an Ohio health care plan, which is the 1394
basic, standard, or carrier reimbursement plan for small employers 1395
and individuals established in accordance with section 3924.10 of 1396
the Revised Code. 1397

Sec. 4123.01. As used in this chapter:	1398
(A)(1) "Employee" means:	1399
(a) Every person in the service of the state, or of any	1400
county, municipal corporation, township, or school district	1401
therein, including regular members of lawfully constituted police	1402
and fire departments of municipal corporations and townships,	1403
whether paid or volunteer, and wherever serving within the state	1404
or on temporary assignment outside thereof, and executive officers	1405
of boards of education, under any appointment or contract of hire,	1406
express or implied, oral or written, including any elected	1407
official of the state, or of any county, municipal corporation, or	1408
township, or members of boards of education.	1409
As used in division (A)(1)(a) of this section, the term	1410
"employee" includes the following persons when responding to an	1411
inherently dangerous situation that calls for an immediate	1412
response on the part of the person, regardless of whether the	1413
person is within the limits of the jurisdiction of the person's	1414
regular employment or voluntary service when responding, on the	1415
condition that the person responds to the situation as the person	1416
otherwise would if the person were on duty in the person's	1417
jurisdiction:	1418
(i) Off-duty peace officers. As used in division (A)(1)(a)(i)	1419
of this section, "peace officer" has the same meaning as in	1420
section 2935.01 of the Revised Code.	1421
(ii) Off-duty firefighters, whether paid or volunteer, of a	1422
lawfully constituted fire department.	1423
(iii) Off-duty first responders, emergency medical	1424
technicians basic, emergency medical technicians intermediate, or	1425
emergency medical technicians paramedic, whether paid or	1426
volunteer, <u>emergency medical workers</u> of an ambulance service	1427

organization or emergency medical service organization pursuant to 1428
~~Chapter 4765. of the Revised Code.~~ 1429

(b) Every person in the service of any person, firm, or 1430
private corporation, including any public service corporation, 1431
that (i) employs one or more persons regularly in the same 1432
business or in or about the same establishment under any contract 1433
of hire, express or implied, oral or written, including aliens and 1434
minors, household workers who earn one hundred sixty dollars or 1435
more in cash in any calendar quarter from a single household and 1436
casual workers who earn one hundred sixty dollars or more in cash 1437
in any calendar quarter from a single employer, or (ii) is bound 1438
by any such contract of hire or by any other written contract, to 1439
pay into the state insurance fund the premiums provided by this 1440
chapter. 1441

(c) Every person who performs labor or provides services 1442
pursuant to a construction contract, as defined in section 4123.79 1443
of the Revised Code, if at least ten of the following criteria 1444
apply: 1445

(i) The person is required to comply with instructions from 1446
the other contracting party regarding the manner or method of 1447
performing services; 1448

(ii) The person is required by the other contracting party to 1449
have particular training; 1450

(iii) The person's services are integrated into the regular 1451
functioning of the other contracting party; 1452

(iv) The person is required to perform the work personally; 1453

(v) The person is hired, supervised, or paid by the other 1454
contracting party; 1455

(vi) A continuing relationship exists between the person and 1456
the other contracting party that contemplates continuing or 1457

recurring work even if the work is not full time;	1458
(vii) The person's hours of work are established by the other contracting party;	1459 1460
(viii) The person is required to devote full time to the business of the other contracting party;	1461 1462
(ix) The person is required to perform the work on the premises of the other contracting party;	1463 1464
(x) The person is required to follow the order of work set by the other contracting party;	1465 1466
(xi) The person is required to make oral or written reports of progress to the other contracting party;	1467 1468
(xii) The person is paid for services on a regular basis such as hourly, weekly, or monthly;	1469 1470
(xiii) The person's expenses are paid for by the other contracting party;	1471 1472
(xiv) The person's tools and materials are furnished by the other contracting party;	1473 1474
(xv) The person is provided with the facilities used to perform services;	1475 1476
(xvi) The person does not realize a profit or suffer a loss as a result of the services provided;	1477 1478
(xvii) The person is not performing services for a number of employers at the same time;	1479 1480
(xviii) The person does not make the same services available to the general public;	1481 1482
(xix) The other contracting party has a right to discharge the person;	1483 1484
(xx) The person has the right to end the relationship with the other contracting party without incurring liability pursuant	1485 1486

to an employment contract or agreement. 1487

Every person in the service of any independent contractor or 1488
subcontractor who has failed to pay into the state insurance fund 1489
the amount of premium determined and fixed by the administrator of 1490
workers' compensation for the person's employment or occupation or 1491
if a self-insuring employer has failed to pay compensation and 1492
benefits directly to the employer's injured and to the dependents 1493
of the employer's killed employees as required by section 4123.35 1494
of the Revised Code, shall be considered as the employee of the 1495
person who has entered into a contract, whether written or verbal, 1496
with such independent contractor unless such employees or their 1497
legal representatives or beneficiaries elect, after injury or 1498
death, to regard such independent contractor as the employer. 1499

(2) "Employee" does not mean: 1500

(a) A duly ordained, commissioned, or licensed minister or 1501
assistant or associate minister of a church in the exercise of 1502
ministry; 1503

(b) Any officer of a family farm corporation; 1504

(c) An individual incorporated as a corporation; or 1505

(d) An individual who otherwise is an employee of an employer 1506
but who signs the waiver and affidavit specified in section 1507
4123.15 of the Revised Code on the condition that the 1508
administrator has granted a waiver and exception to the 1509
individual's employer under section 4123.15 of the Revised Code. 1510

Any employer may elect to include as an "employee" within 1511
this chapter, any person excluded from the definition of 1512
"employee" pursuant to division (A)(2) of this section. If an 1513
employer is a partnership, sole proprietorship, individual 1514
incorporated as a corporation, or family farm corporation, such 1515
employer may elect to include as an "employee" within this 1516
chapter, any member of such partnership, the owner of the sole 1517

proprietorship, the individual incorporated as a corporation, or 1518
the officers of the family farm corporation. In the event of an 1519
election, the employer shall serve upon the bureau of workers' 1520
compensation written notice naming the persons to be covered, 1521
include such employee's remuneration for premium purposes in all 1522
future payroll reports, and no person excluded from the definition 1523
of "employee" pursuant to division (A)(2) of this section, 1524
proprietor, individual incorporated as a corporation, or partner 1525
shall be deemed an employee within this division until the 1526
employer has served such notice. 1527

For informational purposes only, the bureau shall prescribe 1528
such language as it considers appropriate, on such of its forms as 1529
it considers appropriate, to advise employers of their right to 1530
elect to include as an "employee" within this chapter a sole 1531
proprietor, any member of a partnership, an individual 1532
incorporated as a corporation, the officers of a family farm 1533
corporation, or a person excluded from the definition of 1534
"employee" under division (A)(2) of this section, that they should 1535
check any health and disability insurance policy, or other form of 1536
health and disability plan or contract, presently covering them, 1537
or the purchase of which they may be considering, to determine 1538
whether such policy, plan, or contract excludes benefits for 1539
illness or injury that they might have elected to have covered by 1540
workers' compensation. 1541

(B) "Employer" means: 1542

(1) The state, including state hospitals, each county, 1543
municipal corporation, township, school district, and hospital 1544
owned by a political subdivision or subdivisions other than the 1545
state; 1546

(2) Every person, firm, professional employer organization, 1547
and private corporation, including any public service corporation, 1548
that (a) has in service one or more employees or shared employees 1549

regularly in the same business or in or about the same 1550
establishment under any contract of hire, express or implied, oral 1551
or written, or (b) is bound by any such contract of hire or by any 1552
other written contract, to pay into the insurance fund the 1553
premiums provided by this chapter. 1554

All such employers are subject to this chapter. Any member of 1555
a firm or association, who regularly performs manual labor in or 1556
about a mine, factory, or other establishment, including a 1557
household establishment, shall be considered an employee in 1558
determining whether such person, firm, or private corporation, or 1559
public service corporation, has in its service, one or more 1560
employees and the employer shall report the income derived from 1561
such labor to the bureau as part of the payroll of such employer, 1562
and such member shall thereupon be entitled to all the benefits of 1563
an employee. 1564

(C) "Injury" includes any injury, whether caused by external 1565
accidental means or accidental in character and result, received 1566
in the course of, and arising out of, the injured employee's 1567
employment. "Injury" does not include: 1568

(1) Psychiatric conditions except ~~where~~ as follows: 1569

(a) Where the claimant's psychiatric conditions have arisen 1570
from an injury or occupational disease sustained by that claimant 1571
~~or where;~~ 1572

(b) Where the claimant's psychiatric conditions have arisen 1573
from sexual conduct in which the claimant was forced by threat of 1574
physical harm to engage or participate; 1575

(c) Where the claimant is a peace officer, firefighter, or 1576
emergency medical worker and is diagnosed with post-traumatic 1577
stress disorder that has been received in the course of, and has 1578
arisen out of, the claimant's employment as a peace officer, 1579
firefighter, or emergency medical worker. 1580

(2) Injury or disability caused primarily by the natural 1581
deterioration of tissue, an organ, or part of the body; 1582

(3) Injury or disability incurred in voluntary participation 1583
in an employer-sponsored recreation or fitness activity if the 1584
employee signs a waiver of the employee's right to compensation or 1585
benefits under this chapter prior to engaging in the recreation or 1586
fitness activity; 1587

(4) A condition that pre-existed an injury unless that 1588
pre-existing condition is substantially aggravated by the injury. 1589
Such a substantial aggravation must be documented by objective 1590
diagnostic findings, objective clinical findings, or objective 1591
test results. Subjective complaints may be evidence of such a 1592
substantial aggravation. However, subjective complaints without 1593
objective diagnostic findings, objective clinical findings, or 1594
objective test results are insufficient to substantiate a 1595
substantial aggravation. 1596

(D) "Child" includes a posthumous child and a child legally 1597
adopted prior to the injury. 1598

(E) "Family farm corporation" means a corporation founded for 1599
the purpose of farming agricultural land in which the majority of 1600
the voting stock is held by and the majority of the stockholders 1601
are persons or the spouse of persons related to each other within 1602
the fourth degree of kinship, according to the rules of the civil 1603
law, and at least one of the related persons is residing on or 1604
actively operating the farm, and none of whose stockholders are a 1605
corporation. A family farm corporation does not cease to qualify 1606
under this division where, by reason of any devise, bequest, or 1607
the operation of the laws of descent or distribution, the 1608
ownership of shares of voting stock is transferred to another 1609
person, as long as that person is within the degree of kinship 1610
stipulated in this division. 1611

(F) "Occupational disease" means a disease contracted in the 1612
course of employment, which by its causes and the characteristics 1613
of its manifestation or the condition of the employment results in 1614
a hazard which distinguishes the employment in character from 1615
employment generally, and the employment creates a risk of 1616
contracting the disease in greater degree and in a different 1617
manner from the public in general. 1618

(G) "Self-insuring employer" means an employer who is granted 1619
the privilege of paying compensation and benefits directly under 1620
section 4123.35 of the Revised Code, including a board of county 1621
commissioners for the sole purpose of constructing a sports 1622
facility as defined in section 307.696 of the Revised Code, 1623
provided that the electors of the county in which the sports 1624
facility is to be built have approved construction of a sports 1625
facility by ballot election no later than November 6, 1997. 1626

(H) "Private employer" means an employer as defined in 1627
division (B)(2) of this section. 1628

(I) "Professional employer organization" has the same meaning 1629
as in section 4125.01 of the Revised Code. 1630

(J) "Public employer" means an employer as defined in 1631
division (B)(1) of this section. 1632

(K) "Sexual conduct" means vaginal intercourse between a male 1633
and female; anal intercourse, fellatio, and cunnilingus between 1634
persons regardless of gender; and, without privilege to do so, the 1635
insertion, however slight, of any part of the body or any 1636
instrument, apparatus, or other object into the vaginal or anal 1637
cavity of another. Penetration, however slight, is sufficient to 1638
complete vaginal or anal intercourse. 1639

(L) "Other-states' insurer" means an insurance company that 1640
is authorized to provide workers' compensation insurance coverage 1641
in any of the states that permit employers to obtain insurance for 1642

workers' compensation claims through insurance companies. 1643

(M) "Other-states' coverage" means both of the following: 1644

(1) Insurance coverage secured by an eligible employer for 1645
workers' compensation claims of employees who are in employment 1646
relationships localized in a state other than this state or those 1647
employees' dependents; 1648

(2) Insurance coverage secured by an eligible employer for 1649
workers' compensation claims that arise in a state other than this 1650
state where an employer elects to obtain coverage through either 1651
the administrator or an other-states' insurer. 1652

(N) "Limited other-states coverage" means insurance coverage 1653
provided by the administrator to an eligible employer for workers' 1654
compensation claims of employees who are in an employment 1655
relationship localized in this state but are temporarily working 1656
in a state other than this state, or those employees' dependents. 1657

(O) "Peace officer" has the same meaning as in section 1658
2935.01 of the Revised Code. 1659

(P) "Firefighter" means a firefighter, whether paid or 1660
volunteer, of a lawfully constituted fire department. 1661

(Q) "Emergency medical worker" means a first responder, 1662
emergency medical technician-basic, emergency medical 1663
technician-intermediate, or emergency medical 1664
technician-paramedic, certified under Chapter 4765. of the Revised 1665
Code, whether paid or volunteer. 1666

Sec. 4123.026. ~~(A)~~ The administrator of workers' 1667
compensation, or a self-insuring public employer for the peace 1668
officers, firefighters, and emergency medical workers employed by 1669
or volunteering for that self-insuring public employer, shall pay 1670
the costs of conducting post-exposure medical diagnostic services, 1671
consistent with the standards of medical care existing at the time 1672

of the exposure, to investigate whether an injury or occupational 1673
disease was sustained by a peace officer, firefighter, or 1674
emergency medical worker when coming into contact with the blood 1675
or other body fluid of another person in the course of and arising 1676
out of the peace officer's, firefighter's, or emergency medical 1677
worker's employment, or when responding to an inherently dangerous 1678
situation in the manner described in, and in accordance with the 1679
conditions specified under, division (A)(1)(a) of section 4123.01 1680
of the Revised Code, through any of the following means: 1681

~~(1)(A)~~ Splash or spatter in the eye or mouth, including when 1682
received in the course of conducting mouth-to-mouth resuscitation; 1683

~~(2)(B)~~ A puncture in the skin; 1684

~~(3)(C)~~ A cut in the skin or another opening in the skin such 1685
as an open sore, wound, lesion, abrasion, or ulcer. 1686

~~(B) As used in this section:~~ 1687

~~(1) "Peace officer" has the same meaning as in section 1688
2935.01 of the Revised Code. 1689~~

~~(2) "Firefighter" means a firefighter, whether paid or 1690
volunteer, of a lawfully constituted fire department. 1691~~

~~(3) "Emergency medical worker" means a first responder, 1692
emergency medical technician basic, emergency medical 1693
technician intermediate, or emergency medical 1694
technician paramedic, certified under Chapter 4765. of the Revised 1695
Code, whether paid or volunteer. 1696~~

Sec. 4123.46. (A)(1) Except as provided in division (A)(2) of 1697
this section, the bureau of workers' compensation shall disburse 1698
the state insurance fund to employees of employers who have paid 1699
into the fund the premiums applicable to the classes to which they 1700
belong when the employees have been injured in the course of their 1701
employment, wherever the injuries have occurred, and provided the 1702

injuries have not been purposely self-inflicted, or to the 1703
dependents of the employees in case death has ensued. 1704

(2) As long as injuries have not been purposely 1705
self-inflicted, the bureau shall disburse the surplus fund created 1706
under section 4123.34 of the Revised Code to off-duty peace 1707
officers, firefighters, and emergency medical ~~technicians, and~~ 1708
~~first responders~~ workers, or to their dependents if death ensues, 1709
who are injured while responding to inherently dangerous 1710
situations that call for an immediate response on the part of the 1711
person, regardless of whether the person was within the limits of 1712
the person's jurisdiction when responding, on the condition that 1713
the person responds to the situation as the person otherwise would 1714
if the person were on duty in the person's jurisdiction. 1715

As used in division (A)(2) of this section, "peace officer," 1716
"firefighter," and "emergency medical ~~technician,~~" "~~first~~ 1717
~~responder~~ worker," and "~~jurisdiction~~" have the same meanings as in 1718
section 4123.01 of the Revised Code. 1719

(B) All self-insuring employers, in compliance with this 1720
chapter, shall pay the compensation to injured employees, or to 1721
the dependents of employees who have been killed in the course of 1722
their employment, unless the injury or death of the employee was 1723
purposely self-inflicted, and shall furnish the medical, surgical, 1724
nurse, and hospital care and attention or funeral expenses as 1725
would have been paid and furnished by virtue of this chapter under 1726
a similar state of facts by the bureau out of the state insurance 1727
fund if the employer had paid the premium into the fund. 1728

If any rule or regulation of a self-insuring employer 1729
provides for or authorizes the payment of greater compensation or 1730
more complete or extended medical care, nursing, surgical, and 1731
hospital attention, or funeral expenses to the injured employees, 1732
or to the dependents of the employees as may be killed, the 1733
employer shall pay to the employees, or to the dependents of 1734

employees killed, the amount of compensation and furnish the 1735
medical care, nursing, surgical, and hospital attention or funeral 1736
expenses provided by the self-insuring employer's rules and 1737
regulations. 1738

(C) Payment to injured employees, or to their dependents in 1739
case death has ensued, is in lieu of any and all rights of action 1740
against the employer of the injured or killed employees. 1741

Section 2. That existing sections 1739.061, 1751.14, 1751.69, 1742
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 1743
3923.65, 3923.83, 3923.85, 3924.01, 4123.01, 4123.026, and 4123.46 1744
of the Revised Code are hereby repealed. 1745

Section 3. Section 1751.14 and division (G) of section 1746
3924.01 of the Revised Code, as amended by this act, apply only to 1747
policies, contracts, and agreements that are delivered, issued for 1748
delivery, or renewed in this state on or after January 1, 2016. 1749
Division (A)(1) of section 3923.24 and division (A)(1) of section 1750
3923.241 of the Revised Code, as amended by this act, apply only 1751
to policies of sickness and accident insurance delivered, issued 1752
for delivery, or renewed in this state and public employee benefit 1753
plans or multiple employer welfare arrangement contracts and 1754
certificates that are established or modified in this state on or 1755
after January 1, 2016. 1756

Section 4. The General Assembly declares that the amendments 1757
made to section 3923.58 of the Revised Code by this act are not to 1758
supersede the suspension of the operation of this section enacted 1759
by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, 1760
it is the intent of the General Assembly to ensure consistency in 1761
Ohio Insurance Law should this suspension be nullified. 1762