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Senator Eklund

Cosponsors: Senators Beagle, Brown, Gentile, Kearney, Bacon, Balderson, Burke, Cafaro, Coley, Faber, Gardner, Hite, Hughes, Jones, Jordan, LaRose, Lehner, Manning, Obhof, Oelslager, Patton, Peterson, Sawyer, Schaffer, Seitz, Skindell, Tavares, Turner, Uecker, Widener

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A BILL

To amend sections 1739.061, 1751.14, 1751.69, 1
2329.66, 3769.21, 3923.022, 3923.24, 3923.241, 2
3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3
3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 4
and to enact sections 143.01 to 143.11, 505.377, 5
737.082, 737.222, and 4731.056 of the Revised Code 6
to create the Volunteer Peace Officers' Dependents 7
Fund to provide death benefits to survivors of 8
volunteer peace officers killed in the line of 9
duty and disability benefits to disabled volunteer 10
peace officers, to clarify the status of volunteer 11
firefighters for purposes of the Patient 12
Protection and Affordable Care Act, to make 13
changes regarding coverage for a dependent child 14
under a parent's health insurance plan and the 15

hours of work needed to qualify for coverage under 16
a small employer health benefit plan, to increase 17
the duration of the health insurance considered to 18
be short-term under certain insurance laws, and to 19
make changes to the chemotherapy parity law, to 20
establish requirements regarding controlled 21
substances containing buprenorphine used for the 22
purpose of treating drug dependence or addiction, 23
and to specify the use of video lottery terminal 24
revenue. 25

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

Section 1. That sections 1739.061, 1751.14, 1751.69, 2329.66, 26
3769.21, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 27
3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 28
4729.541 be amended and sections 143.01, 143.02, 143.03, 143.04, 29
143.05, 143.06, 143.07, 143.08, 143.09, 143.10, 143.11, 505.377, 30
737.082, 737.222, and 4731.056 of the Revised Code be enacted to 31
read as follows: 32

Sec. 143.01. As used in this chapter: 33

(A) "Killed in the line of duty" means either of the 34
following: 35

(1) Death in the line of duty; 36

(2) Death from injury sustained in the line of duty, 37
including heart attack or other fatal injury or illness caused 38
while in the line of duty. 39

(B) "Totally and permanently disabled" means unable to engage 40
in any substantial gainful employment for a period of not less 41
than twelve months by reason of a medically determinable physical 42
impairment that is permanent or presumed to be permanent. 43

(C) "Volunteer peace officer" means any person who is 44
employed as a police officer, sheriff's deputy, constable, or 45
deputy marshal in a part-time, reserve, or volunteer capacity by a 46
county sheriff's department or the police department of a 47
municipal corporation, township, township police district, or 48
joint police district and is not a member of the public employees 49
retirement system, Ohio police and fire pension fund, state 50
highway patrol retirement system, or the Cincinnati retirement 51
system. 52

Sec. 143.02. (A) There is hereby established the volunteer 53
peace officers dependents fund. 54

Each county, municipal corporation, township, township police 55
district, and joint police district with a police or sheriff's 56
department that employs volunteer peace officers is a member of 57
the volunteer peace officers' dependents fund and shall establish 58
a volunteer peace officers' dependents fund board. Each board 59
shall consist of the following board members: 60

(1) Two board members, elected by the legislative authority 61
of the fund member that maintains the police or sheriff's 62
department; 63

(2) Two board members, elected by the volunteer peace 64
officers of the police or sheriff's department; 65

(3) One board member, elected by the board members elected 66
pursuant to divisions (A)(1) and (2) of this section. The board 67
member must be an elector of the fund member in which the police 68
or sheriff's department is located, but not a public employee, 69
member of the legislative authority, or peace officer of that 70
peace or sheriff's department. 71

(B) The term of office of a board member begins the first day 72
of January and is one year. 73

(C)(1) The election of the board members specified in 74
division (A)(1) of this section shall be held each year not 75
earlier than the first day of November and not later than the 76
second Monday in December. The election of the member specified in 77
division (A)(3) of this section shall be held each year on or 78
before the thirty-first day of December. 79

(2) The members specified in division (A)(2) of this section 80
shall be elected on or before the second Monday in December, as 81
follows: 82

(a) The secretary of the board shall give notice of the 83
election by posting it in a conspicuous place at the headquarters 84
of the police or sheriff's department. Between nine a.m. and nine 85
p.m. on the day designated, each person eligible to vote shall 86
send in writing the name of two persons eligible to be elected to 87
the board who are the person's choices. 88

(b) All votes cast at the election shall be counted and 89
recorded by the board, which shall announce the result. The two 90
persons receiving the highest number of votes are elected. If 91
there is a tie vote for any two persons, the election shall be 92
decided by lot or in any other way agreed on by the persons for 93
whom the tie vote was cast. 94

(D) Any vacancy occurring on a board shall be filled at a 95
special election called by the board's secretary. 96

Sec. 143.03. A volunteer peace officers' dependents fund 97
board shall meet promptly after election of the board's members 98
and organize. The board shall select from among its members a 99
chairperson and a secretary. 100

The secretary of the board shall keep a complete record of 101
the board's proceedings, which shall be maintained as a permanent 102
file. 103

<u>Board members shall serve without compensation.</u>	104
<u>The legislative authority of the fund member shall provide</u>	105
<u>sufficient meeting space and supplies for the board to carry out</u>	106
<u>its duties.</u>	107
<u>The secretary shall submit all of the following to the</u>	108
<u>director of commerce:</u>	109
<u>(A) The name and address of each board member and an</u>	110
<u>indication of the group or authority that elected the member;</u>	111
<u>(B) The names of the chairperson and secretary;</u>	112
<u>(C) A certificate indicating the current assessed property</u>	113
<u>valuation of the fund member that is prepared by the clerk of the</u>	114
<u>fund member.</u>	115
<u>Sec. 143.04.</u> <u>Each volunteer peace officers' dependents fund</u>	116
<u>board may adopt rules as necessary for handling and processing</u>	117
<u>claims for benefits.</u>	118
<u>The board shall perform such other duties as are necessary to</u>	119
<u>implement this chapter.</u>	120
<u>Sec. 143.05.</u> <u>The prosecuting attorney of the county in which</u>	121
<u>a fund member is located shall serve as the legal advisor for the</u>	122
<u>volunteer peace officer's dependents' board.</u>	123
<u>Sec. 143.06.</u> <u>(A) The volunteer peace officers' dependents</u>	124
<u>fund shall be maintained in the state treasury. All investment</u>	125
<u>earnings of the fund shall be collected by the treasurer of state</u>	126
<u>and placed to the credit of the fund.</u>	127
<u>(B) Each fund member shall pay to the treasurer of state, to</u>	128
<u>the credit of the fund, an initial premium as follows:</u>	129
<u>(1) Each member with an assessed property valuation of less</u>	130
<u>than seven million dollars, three hundred dollars;</u>	131

(2) Each member with an assessed property valuation of seven million dollars but less than fourteen million dollars, three hundred fifty dollars; 132
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(3) Each member with an assessed property valuation of fourteen million dollars but less than twenty-one million dollars, four hundred dollars; 135
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(4) Each member with an assessed property valuation of twenty-one million dollars but less than twenty-eight million dollars, four hundred fifty dollars; 138
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(5) Each member with an assessed property valuation of twenty-eight million dollars or over, five hundred dollars. 141
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Sec. 143.07. The total of all initial premiums collected by the treasurer of state under section 143.06 of the Revised Code is the basic capital account of the volunteer peace officers' dependents fund. No further contributions are required of fund members until claims against the fund have reduced it to ninety-five per cent or less of its basic capital account. In that event, the director of commerce shall cause the following assessments, based on current property valuation, to be made and certified to the legislative authority of each member of the fund: 143
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(A) Each member with an assessed property valuation of less than seven million dollars, ninety dollars; 152
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(B) Each member with an assessed property valuation of seven million dollars but less than fourteen million dollars, one hundred five dollars; 154
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(C) Each member with an assessed property valuation of fourteen million dollars but less than twenty-one million dollars, one hundred twenty dollars; 157
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(D) Each member with an assessed property valuation of twenty-one million dollars but less than twenty-eight million 160
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dollars, one hundred thirty-five dollars; 162

(E) Each member with an assessed property valuation of 163

twenty-eight million dollars or more, one hundred fifty dollars. 164

Sec. 143.08. (A) If a premium is not paid as provided in 165

section 143.06 of the Revised Code, the director of commerce shall 166

certify the failure as an assessment against the fund member to 167

the auditor of the county within which the member is located. The 168

county auditor shall withhold the amount of the assessment, 169

together with interest at the rate of six per cent from the due 170

date of the premium, from the next ensuing tax settlement due the 171

member and pay the amount to the treasurer of state to the credit 172

of the volunteer peace officers' dependents fund. 173

If the secretary of a volunteer peace officers' dependents 174

fund board fails to submit to the director a certificate of the 175

current assessed property valuation in accordance with section 176

143.03 of the Revised Code, the director shall use division (B)(5) 177

of section 143.06 of the Revised Code as a basis for the 178

assessment. 179

(B) If a fund member does not pay the assessment provided in 180

section 143.07 of the Revised Code within forty-five days after 181

notice, the director shall proceed with collection in accordance 182

with division (A) of this section. 183

Sec. 143.09. (A) A volunteer peace officer who is totally and 184

permanently disabled as a result of discharging the duties of a 185

volunteer peace officer shall receive a benefit from the volunteer 186

peace officers' dependents fund of three hundred dollars per 187

month, except that no payment shall be made to a volunteer peace 188

officer who is receiving the officer's full salary during the time 189

of the officer's disability. 190

(B) Regardless of whether the volunteer peace officer 191

received a benefit under division (A) of this section, death 192
benefits shall be paid from the fund to the surviving spouse or 193
dependent children of a volunteer peace officer who is killed in 194
the line of duty. Death benefits shall be paid as follows: 195

(1) To the surviving spouse of a volunteer peace officer 196
killed in the line of duty, an award of one thousand dollars, and 197
in addition, a benefit of three hundred dollars per month; 198

(2) To the parent, guardian, or other persons on whom a child 199
of a volunteer peace officer killed in the line of duty is 200
dependent for chief financial support, a benefit of one hundred 201
twenty-five dollars per month for each dependent child under age 202
eighteen, or under age twenty-two if attending an institution of 203
learning or training pursuant to a program designed to complete in 204
each school year the equivalent of at least two-thirds of the 205
full-time curriculum requirements of the institution. 206

(C) An individual eligible for benefits payable under this 207
section shall file a claim for benefits with the appropriate 208
volunteer peace officers' dependents fund board on a form provided 209
by the board. All of the following information shall be submitted 210
with the claim: 211

(1) In the case of a totally and permanently disabled 212
volunteer peace officer, the following: 213

(a) The name of the police or sheriff's department for which 214
the officer was a volunteer peace officer; 215

(b) The date of the injury; 216

(c) Satisfactory medical evidence that the officer is totally 217
and permanently disabled. 218

(2) In the case of a surviving spouse or a parent, guardian, 219
or other person in charge of a dependent child, the following: 220

(a) The full name of the deceased volunteer peace officer; 221

(b) The name of the police or sheriff's department for which 222
the deceased officer was a volunteer peace officer; 223

(c) The name and address of the surviving spouse, as 224
applicable; 225

(d) The names, ages, and addresses of any dependent children; 226

(e) Any other evidence required by the board. 227

(D) All claimants shall certify that neither the claimant nor 228
the person on whose behalf the claim is filed qualifies for other 229
benefits from any of the following based on the officer's service 230
as a volunteer peace officer: the public employees retirement 231
system, Ohio police and fire pension fund, state highway patrol 232
retirement system, Cincinnati retirement system, or Ohio public 233
safety officers death benefit fund. 234

(E) Initial claims shall be filed with the volunteer peace 235
officers' dependents fund board of the fund member in which the 236
officer was a volunteer peace officer. Thereafter, on request of 237
the claimant or the board, claims may be transferred to a board 238
near the claimant's current residence, if the boards concerned 239
agree to the transfer. 240

Sec. 143.10. (A)(1) Not later than five days after receipt of 241
a claim for benefits, a volunteer peace officers' dependents fund 242
board shall meet and determine the validity of the claim. If the 243
board determines that the claim is valid, it shall make a 244
determination of the amount due and certify its determination to 245
the director of commerce for payment. The certificate shall show 246
the name and address of the board, the name and address of each 247
beneficiary, the amount to be received by or on behalf of each 248
beneficiary, and the name and address of the person to whom 249
payments are to be made. 250

(2) If the board determines that a claimant is ineligible for 251

benefits, the board shall deny the claim and issue to the claimant 252
a copy of its order. 253

(B) The board may make a continuing order for monthly 254
payments to a claimant for a period not exceeding three months 255
from the date of the determination. The determination may be 256
modified after issuance to reflect any changes in the claimant's 257
eligibility. If no changes occur at the end of the three-month 258
period, the director may provide for payment if the board 259
certifies that the original certificate is continued for an 260
additional three-month period. 261

Sec. 143.11. The right of an individual to a benefit under 262
this chapter shall not be subject to execution, garnishment, 263
attachment, the operation of bankruptcy or insolvency laws, or 264
other process of law whatsoever, and shall be unassignable except 265
as specifically provided in this chapter and sections 3105.171, 266
3105.65, and 3115.32 and Chapters 3119., 3121., 3123., and 3125. 267
of the Revised Code. 268

Sec. 505.377. A volunteer firefighter appointed pursuant to 269
this chapter is a bona fide volunteer and not an employee for 270
purposes of section 513 of the "Patient Protection and Affordable 271
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 272
providing those fire protection services, the volunteer receives 273
any of the benefits provided in Chapter 146., 4121., or 4123. or 274
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 275
Code. 276

Sec. 737.082. A volunteer firefighter appointed pursuant to 277
this chapter is a bona fide volunteer and not an employee for 278
purposes of section 513 of the "Patient Protection and Affordable 279
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 280
providing those fire protection services, the volunteer receives 281

any of the benefits provided in Chapter 146., 4121., or 4123. or 282
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 283
Code. 284

Sec. 737.222. A volunteer firefighter appointed pursuant to 285
this chapter is a bona fide volunteer and not an employee for 286
purposes of section 513 of the "Patient Protection and Affordable 287
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 288
providing those fire protection services, the volunteer receives 289
any of the benefits provided in Chapter 146., 4121., or 4123. or 290
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 291
Code. 292

Sec. 1739.061. (A)(1) This section applies to both of the 293
following: 294

(a) A multiple employer welfare arrangement that issues or 295
requires the use of a standardized identification card or an 296
electronic technology for submission and routing of prescription 297
drug claims; 298

(b) A person or entity that a multiple employer welfare 299
arrangement contracts with to issue a standardized identification 300
card or an electronic technology described in division (A)(1)(a) 301
of this section. 302

(2) Notwithstanding division (A)(1) of this section, this 303
section does not apply to the issuance or required use of a 304
standardized identification card or an electronic technology for 305
the submission and routing of prescription drug claims in 306
connection with any of the following: 307

(a) Any program or arrangement covering only accident, 308
credit, dental, disability income, long-term care, hospital 309
indemnity, medicare supplement, medicare, tricare, specified 310

disease, or vision care; coverage under a 311
one-time-limited-duration policy ~~of not longer~~ that is less than 312
~~six~~ twelve months; coverage issued as a supplement to liability 313
insurance; insurance arising out of workers' compensation or 314
similar law; automobile medical payment insurance; or insurance 315
under which benefits are payable with or without regard to fault 316
and which is statutorily required to be contained in any liability 317
insurance policy or equivalent self-insurance. 318

(b) Coverage provided under the medicaid program. 319

(c) Coverage provided under an employer's self-insurance plan 320
or by any of its administrators, as defined in section 3959.01 of 321
the Revised Code, to the extent that federal law supersedes, 322
preempts, prohibits, or otherwise precludes the application of 323
this section to the plan and its administrators. 324

(B) A standardized identification card or an electronic 325
technology issued or required to be used as provided in division 326
(A)(1) of this section shall contain uniform prescription drug 327
information in accordance with either division (B)(1) or (2) of 328
this section. 329

(1) The standardized identification card or the electronic 330
technology shall be in a format and contain information fields 331
approved by the national council for prescription drug programs or 332
a successor organization, as specified in the council's or 333
successor organization's pharmacy identification card 334
implementation guide in effect on the first day of October most 335
immediately preceding the issuance or required use of the 336
standardized identification card or the electronic technology. 337

(2) If the multiple employer welfare arrangement or person 338
under contract with it to issue a standardized identification card 339
or an electronic technology requires the information for the 340
submission and routing of a claim, the standardized identification 341

card or the electronic technology shall contain any of the 342
following information: 343

(a) The name of the multiple employer welfare arrangement; 344

(b) The individual's name, group number, and identification 345
number; 346

(c) A telephone number to inquire about pharmacy-related 347
issues; 348

(d) The issuer's international identification number, labeled 349
as "ANSI BIN" or "RxBIN"; 350

(e) The processor's control number, labeled as "RxPCN"; 351

(f) The individual's pharmacy benefits group number if 352
different from the insured's medical group number, labeled as 353
"RxGrp." 354

(C) If the standardized identification card or the electronic 355
technology issued or required to be used as provided in division 356
(A)(1) of this section is also used for submission and routing of 357
nonpharmacy claims, the designation "Rx" is required to be 358
included as part of the labels identified in divisions (B)(2)(d) 359
and (e) of this section if the issuer's international 360
identification number or the processor's control number is 361
different for medical and pharmacy claims. 362

(D) Each multiple employer welfare arrangement described in 363
division (A) of this section shall annually file a certificate 364
with the superintendent of insurance certifying that it or any 365
person it contracts with to issue a standardized identification 366
card or electronic technology for submission and routing of 367
prescription drug claims complies with this section. 368

(E)(1) Except as provided in division (E)(2) of this section, 369
if there is a change in the information contained in the 370
standardized identification card or the electronic technology 371

issued to an individual, the multiple employer welfare arrangement 372
or person under contract with it to issue a standardized 373
identification card or an electronic technology shall issue a new 374
card or electronic technology to the individual. 375

(2) A multiple employer welfare arrangement or person under 376
contract with it is not required under division (E)(1) of this 377
section to issue a new card or electronic technology to an 378
individual more than once during a twelve-month period. 379

(F) Nothing in this section shall be construed as requiring a 380
multiple employer welfare arrangement to produce more than one 381
standardized identification card or one electronic technology for 382
use by individuals accessing health care benefits provided under a 383
multiple employer welfare arrangement. 384

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the 385
Revised Code, any policy, contract, or agreement for health care 386
services authorized by this chapter that is issued, delivered, or 387
renewed in this state and that provides that coverage of an 388
unmarried dependent child will terminate upon attainment of the 389
limiting age for dependent children specified in the policy, 390
contract, or agreement, shall also provide in substance both of 391
the following: 392

(1) Once an unmarried child has attained the limiting age for 393
dependent children, as provided in the policy, contract, or 394
agreement, upon the request of the subscriber, the health insuring 395
corporation shall offer to cover the unmarried child until the 396
child attains ~~twenty-eight~~ twenty-six years of age if all of the 397
following are true: 398

(a) The child is the natural child, stepchild, or adopted 399
child of the subscriber. 400

(b) The child is a resident of this state or a full-time 401

student at an accredited public or private institution of higher education. 402
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(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage. 404
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(d) The child is not eligible for coverage under the medicaid program or the medicare program. 407
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(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following: 409
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(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; 413
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(b) Primarily dependent upon the subscriber for support and maintenance. 415
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(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. 417
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(C) Nothing in this section shall do any of the following: 424

(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; 425
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(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 429
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agreement;	432
(3) Require an employer to offer health insurance coverage to the dependents of any employee.	433 434
(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.	435 436 437 438
(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:	439 440 441
(1) A public employee benefit plan;	442
(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.	443 444
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.	445 446 447 448 449 450
(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:	451 452 453 454 455 456 457 458
(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	459 460 461

coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications. 462
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(2) The policy, contract, or agreement shall not comply with 464
division (B)(1) of this section by imposing an increase in cost 465
sharing solely for orally administered, intravenously 466
administered, or injected cancer medications. 467

(C) Notwithstanding any provision of this section to the 468
contrary, an individual or group health insuring corporation 469
policy, contract, or agreement shall be deemed to be in compliance 470
with this section if the cost sharing imposed under such a policy, 471
contract, or agreement for orally administered cancer treatments 472
does not exceed one hundred dollars per prescription fill. The 473
cost sharing limit of one hundred dollars per prescription fill 474
shall apply to a high deductible plan, as defined in 26 U.S.C. 475
223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only 476
after the deductible has been met. 477

(D) The prohibitions in division (B) of this section do not 478
preclude an individual or group health insuring corporation 479
policy, contract, or agreement from requiring an enrollee to 480
obtain prior authorization before orally administered cancer 481
medication is dispensed to the enrollee. 482

(E) A health insuring corporation that offers coverage for 483
basic health care services is not required to comply with division 484
(B) of this section if all of the following apply: 485

(1) The health insuring corporation submits documentation 486
certified by an independent member of the American academy of 487
actuaries to the superintendent of insurance showing that 488
compliance with division (B)(1) of this section for a period of at 489
least six months independently caused the health insuring 490
corporation's costs for claims and administrative expenses for the 491
coverage of basic health care services to increase by more than 492

one per cent per year. 493

(2) The health insuring corporation submits a signed letter 494
from an independent member of the American academy of actuaries to 495
the superintendent of insurance opining that the increase in costs 496
described in division (E)(1) of this section could reasonably 497
justify an increase of more than one per cent in the annual 498
premiums or rates charged by the health insuring corporation for 499
the coverage of basic health care services. 500

(3)(a) The superintendent of insurance makes the following 501
determinations from the documentation and opinion submitted 502
pursuant to divisions (E)(1) and (2) of this section: 503

(i) Compliance with division (B)(1) of this section for a 504
period of at least six months independently caused the health 505
insuring corporation's costs for claims and administrative 506
expenses for the coverage of basic health care services to 507
increase more than one per cent per year. 508

(ii) The increase in costs reasonably justifies an increase 509
of more than one per cent in the annual premiums or rates charged 510
by the health insuring corporation for the coverage of basic 511
health care services. 512

(b) Any determination made by the superintendent under 513
division (E)(3) of this section is subject to Chapter 119. of the 514
Revised Code. 515

Sec. 2329.66. (A) Every person who is domiciled in this state 516
may hold property exempt from execution, garnishment, attachment, 517
or sale to satisfy a judgment or order, as follows: 518

(1)(a) In the case of a judgment or order regarding money 519
owed for health care services rendered or health care supplies 520
provided to the person or a dependent of the person, one parcel or 521
item of real or personal property that the person or a dependent 522

of the person uses as a residence. Division (A)(1)(a) of this 523
section does not preclude, affect, or invalidate the creation 524
under this chapter of a judgment lien upon the exempted property 525
but only delays the enforcement of the lien until the property is 526
sold or otherwise transferred by the owner or in accordance with 527
other applicable laws to a person or entity other than the 528
surviving spouse or surviving minor children of the judgment 529
debtor. Every person who is domiciled in this state may hold 530
exempt from a judgment lien created pursuant to division (A)(1)(a) 531
of this section the person's interest, not to exceed one hundred 532
twenty-five thousand dollars, in the exempted property. 533

(b) In the case of all other judgments and orders, the 534
person's interest, not to exceed one hundred twenty-five thousand 535
dollars, in one parcel or item of real or personal property that 536
the person or a dependent of the person uses as a residence. 537

(c) For purposes of divisions (A)(1)(a) and (b) of this 538
section, "parcel" means a tract of real property as identified on 539
the records of the auditor of the county in which the real 540
property is located. 541

(2) The person's interest, not to exceed three thousand two 542
hundred twenty-five dollars, in one motor vehicle; 543

(3) The person's interest, not to exceed four hundred 544
dollars, in cash on hand, money due and payable, money to become 545
due within ninety days, tax refunds, and money on deposit with a 546
bank, savings and loan association, credit union, public utility, 547
landlord, or other person, other than personal earnings. 548

(4)(a) The person's interest, not to exceed five hundred 549
twenty-five dollars in any particular item or ten thousand seven 550
hundred seventy-five dollars in aggregate value, in household 551
furnishings, household goods, wearing apparel, appliances, books, 552
animals, crops, musical instruments, firearms, and hunting and 553

fishing equipment that are held primarily for the personal,	554
family, or household use of the person;	555
(b) The person's aggregate interest in one or more items of	556
jewelry, not to exceed one thousand three hundred fifty dollars,	557
held primarily for the personal, family, or household use of the	558
person or any of the person's dependents.	559
(5) The person's interest, not to exceed an aggregate of two	560
thousand twenty-five dollars, in all implements, professional	561
books, or tools of the person's profession, trade, or business,	562
including agriculture;	563
(6)(a) The person's interest in a beneficiary fund set apart,	564
appropriated, or paid by a benevolent association or society, as	565
exempted by section 2329.63 of the Revised Code;	566
(b) The person's interest in contracts of life or endowment	567
insurance or annuities, as exempted by section 3911.10 of the	568
Revised Code;	569
(c) The person's interest in a policy of group insurance or	570
the proceeds of a policy of group insurance, as exempted by	571
section 3917.05 of the Revised Code;	572
(d) The person's interest in money, benefits, charity,	573
relief, or aid to be paid, provided, or rendered by a fraternal	574
benefit society, as exempted by section 3921.18 of the Revised	575
Code;	576
(e) The person's interest in the portion of benefits under	577
policies of sickness and accident insurance and in lump sum	578
payments for dismemberment and other losses insured under those	579
policies, as exempted by section 3923.19 of the Revised Code.	580
(7) The person's professionally prescribed or medically	581
necessary health aids;	582
(8) The person's interest in a burial lot, including, but not	583

limited to, exemptions under section 517.09 or 1721.07 of the Revised Code;

(9) The person's interest in the following:

(a) Moneys paid or payable for living maintenance or rights, as exempted by section 3304.19 of the Revised Code;

(b) Workers' compensation, as exempted by section 4123.67 of the Revised Code;

(c) Unemployment compensation benefits, as exempted by section 4141.32 of the Revised Code;

(d) Cash assistance payments under the Ohio works first program, as exempted by section 5107.75 of the Revised Code;

(e) Benefits and services under the prevention, retention, and contingency program, as exempted by section 5108.08 of the Revised Code;

(f) Disability financial assistance payments, as exempted by section 5115.06 of the Revised Code;

(g) Payments under section 24 or 32 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.

(10)(a) Except in cases in which the person was convicted of or pleaded guilty to a violation of section 2921.41 of the Revised Code and in which an order for the withholding of restitution from payments was issued under division (C)(2)(b) of that section, in cases in which an order for withholding was issued under section 2907.15 of the Revised Code, in cases in which an order for forfeiture was issued under division (A) or (B) of section 2929.192 of the Revised Code, and in cases in which an order was issued under section 2929.193 or 2929.194 of the Revised Code, and only to the extent provided in the order, and except as provided in sections 3105.171, 3105.63, 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, the person's rights to or

interests in a pension, benefit, annuity, retirement allowance, or 614
accumulated contributions, the person's rights to or interests in 615
a participant account in any deferred compensation program offered 616
by the Ohio public employees deferred compensation board, a 617
government unit, or a municipal corporation, or the person's other 618
accrued or accruing rights or interests, as exempted by section 619
143.11, 145.56, 146.13, 148.09, 742.47, 3307.41, 3309.66, or 620
5505.22 of the Revised Code, and the person's rights to or 621
interests in benefits from the Ohio public safety officers death 622
benefit fund; 623

(b) Except as provided in sections 3119.80, 3119.81, 3121.02, 624
3121.03, and 3123.06 of the Revised Code, the person's rights to 625
receive or interests in receiving a payment or other benefits 626
under any pension, annuity, or similar plan or contract, not 627
including a payment or benefit from a stock bonus or 628
profit-sharing plan or a payment included in division (A)(6)(b) or 629
(10)(a) of this section, on account of illness, disability, death, 630
age, or length of service, to the extent reasonably necessary for 631
the support of the person and any of the person's dependents, 632
except if all the following apply: 633

(i) The plan or contract was established by or under the 634
auspices of an insider that employed the person at the time the 635
person's rights or interests under the plan or contract arose. 636

(ii) The payment is on account of age or length of service. 637

(iii) The plan or contract is not qualified under the 638
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as 639
amended. 640

(c) Except for any portion of the assets that were deposited 641
for the purpose of evading the payment of any debt and except as 642
provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 643
3123.06 of the Revised Code, the person's rights or interests in 644

the assets held in, or to directly or indirectly receive any 645
payment or benefit under, any individual retirement account, 646
individual retirement annuity, "Roth IRA," "529 plan," or 647
education individual retirement account that provides payments or 648
benefits by reason of illness, disability, death, retirement, or 649
age or provides payments or benefits for purposes of education, to 650
the extent that the assets, payments, or benefits described in 651
division (A)(10)(c) of this section are attributable to or derived 652
from any of the following or from any earnings, dividends, 653
interest, appreciation, or gains on any of the following: 654

(i) Contributions of the person that were less than or equal 655
to the applicable limits on deductible contributions to an 656
individual retirement account or individual retirement annuity in 657
the year that the contributions were made, whether or not the 658
person was eligible to deduct the contributions on the person's 659
federal tax return for the year in which the contributions were 660
made; 661

(ii) Contributions of the person that were less than or equal 662
to the applicable limits on contributions to a Roth IRA or 663
education individual retirement account in the year that the 664
contributions were made; 665

(iii) Contributions of the person that are within the 666
applicable limits on rollover contributions under subsections 219, 667
402(c), 403(a)(4), 403(b)(8), 408(b), 408(d)(3), 408A(c)(3)(B), 668
408A(d)(3), and 530(d)(5) of the "Internal Revenue Code of 1986," 669
100 Stat. 2085, 26 U.S.C.A. 1, as amended; 670

(iv) Contributions by any person into any plan, fund, or 671
account that is formed, created, or administered pursuant to, or 672
is otherwise subject to, section 529 of the "Internal Revenue Code 673
of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended. 674

(d) Except for any portion of the assets that were deposited 675

for the purpose of evading the payment of any debt and except as 676
provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 677
3123.06 of the Revised Code, the person's rights or interests in 678
the assets held in, or to receive any payment under, any Keogh or 679
"H.R. 10" plan that provides benefits by reason of illness, 680
disability, death, retirement, or age, to the extent reasonably 681
necessary for the support of the person and any of the person's 682
dependents. 683

(e) The person's rights to or interests in any assets held 684
in, or to directly or indirectly receive any payment or benefit 685
under, any individual retirement account, individual retirement 686
annuity, "Roth IRA," "529 plan," or education individual 687
retirement account that a decedent, upon or by reason of the 688
decedent's death, directly or indirectly left to or for the 689
benefit of the person, either outright or in trust or otherwise, 690
including, but not limited to, any of those rights or interests in 691
assets or to receive payments or benefits that were transferred, 692
conveyed, or otherwise transmitted by the decedent by means of a 693
will, trust, exercise of a power of appointment, beneficiary 694
designation, transfer or payment on death designation, or any 695
other method or procedure. 696

(f) The exemptions under divisions (A)(10)(a) to (e) of this 697
section also shall apply or otherwise be available to an alternate 698
payee under a qualified domestic relations order (QDRO) or other 699
similar court order. 700

(g) A person's interest in any plan, program, instrument, or 701
device described in divisions (A)(10)(a) to (e) of this section 702
shall be considered an exempt interest even if the plan, program, 703
instrument, or device in question, due to an error made in good 704
faith, failed to satisfy any criteria applicable to that plan, 705
program, instrument, or device under the "Internal Revenue Code of 706
1986," 100 Stat. 2085, 26 U.S.C. 1, as amended. 707

(11) The person's right to receive spousal support, child support, an allowance, or other maintenance to the extent reasonably necessary for the support of the person and any of the person's dependents;

(12) The person's right to receive, or moneys received during the preceding twelve calendar months from, any of the following:

(a) An award of reparations under sections 2743.51 to 2743.72 of the Revised Code, to the extent exempted by division (D) of section 2743.66 of the Revised Code;

(b) A payment on account of the wrongful death of an individual of whom the person was a dependent on the date of the individual's death, to the extent reasonably necessary for the support of the person and any of the person's dependents;

(c) Except in cases in which the person who receives the payment is an inmate, as defined in section 2969.21 of the Revised Code, and in which the payment resulted from a civil action or appeal against a government entity or employee, as defined in section 2969.21 of the Revised Code, a payment, not to exceed twenty thousand two hundred dollars, on account of personal bodily injury, not including pain and suffering or compensation for actual pecuniary loss, of the person or an individual for whom the person is a dependent;

(d) A payment in compensation for loss of future earnings of the person or an individual of whom the person is or was a dependent, to the extent reasonably necessary for the support of the debtor and any of the debtor's dependents.

(13) Except as provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, personal earnings of the person owed to the person for services in an amount equal to the greater of the following amounts:

(a) If paid weekly, thirty times the current federal minimum

hourly wage; if paid biweekly, sixty times the current federal 739
minimum hourly wage; if paid semimonthly, sixty-five times the 740
current federal minimum hourly wage; or if paid monthly, one 741
hundred thirty times the current federal minimum hourly wage that 742
is in effect at the time the earnings are payable, as prescribed 743
by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 744
U.S.C. 206(a)(1), as amended; 745

(b) Seventy-five per cent of the disposable earnings owed to 746
the person. 747

(14) The person's right in specific partnership property, as 748
exempted by the person's rights in a partnership pursuant to 749
section 1776.50 of the Revised Code, except as otherwise set forth 750
in section 1776.50 of the Revised Code; 751

(15) A seal and official register of a notary public, as 752
exempted by section 147.04 of the Revised Code; 753

(16) The person's interest in a tuition unit or a payment 754
under section 3334.09 of the Revised Code pursuant to a tuition 755
payment contract, as exempted by section 3334.15 of the Revised 756
Code; 757

(17) Any other property that is specifically exempted from 758
execution, attachment, garnishment, or sale by federal statutes 759
other than the "Bankruptcy Reform Act of 1978," 92 Stat. 2549, 11 760
U.S.C.A. 101, as amended; 761

(18) The person's aggregate interest in any property, not to 762
exceed one thousand seventy-five dollars, except that division 763
(A)(18) of this section applies only in bankruptcy proceedings. 764

(B) On April 1, 2010, and on the first day of April in each 765
third calendar year after 2010, the Ohio judicial conference shall 766
adjust each dollar amount set forth in this section to reflect any 767
increase in the consumer price index for all urban consumers, as 768
published by the United States department of labor, or, if that 769

index is no longer published, a generally available comparable 770
index, for the three-year period ending on the thirty-first day of 771
December of the preceding year. Any adjustments required by this 772
division shall be rounded to the nearest twenty-five dollars. 773

The Ohio judicial conference shall prepare a memorandum 774
specifying the adjusted dollar amounts. The judicial conference 775
shall transmit the memorandum to the director of the legislative 776
service commission, and the director shall publish the memorandum 777
in the register of Ohio. (Publication of the memorandum in the 778
register of Ohio shall continue until the next memorandum 779
specifying an adjustment is so published.) The judicial conference 780
also may publish the memorandum in any other manner it concludes 781
will be reasonably likely to inform persons who are affected by 782
its adjustment of the dollar amounts. 783

(C) As used in this section: 784

(1) "Disposable earnings" means net earnings after the 785
garnishee has made deductions required by law, excluding the 786
deductions ordered pursuant to section 3119.80, 3119.81, 3121.02, 787
3121.03, or 3123.06 of the Revised Code. 788

(2) "Insider" means: 789

(a) If the person who claims an exemption is an individual, a 790
relative of the individual, a relative of a general partner of the 791
individual, a partnership in which the individual is a general 792
partner, a general partner of the individual, or a corporation of 793
which the individual is a director, officer, or in control; 794

(b) If the person who claims an exemption is a corporation, a 795
director or officer of the corporation; a person in control of the 796
corporation; a partnership in which the corporation is a general 797
partner; a general partner of the corporation; or a relative of a 798
general partner, director, officer, or person in control of the 799
corporation; 800

(c) If the person who claims an exemption is a partnership, a general partner in the partnership; a general partner of the partnership; a person in control of the partnership; a partnership in which the partnership is a general partner; or a relative in, a general partner of, or a person in control of the partnership;

(d) An entity or person to which or whom any of the following applies:

(i) The entity directly or indirectly owns, controls, or holds with power to vote, twenty per cent or more of the outstanding voting securities of the person who claims an exemption, unless the entity holds the securities in a fiduciary or agency capacity without sole discretionary power to vote the securities or holds the securities solely to secure to debt and the entity has not in fact exercised the power to vote.

(ii) The entity is a corporation, twenty per cent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by the person who claims an exemption or by an entity to which division (C)(2)(d)(i) of this section applies.

(iii) A person whose business is operated under a lease or operating agreement by the person who claims an exemption, or a person substantially all of whose business is operated under an operating agreement with the person who claims an exemption.

(iv) The entity operates the business or all or substantially all of the property of the person who claims an exemption under a lease or operating agreement.

(e) An insider, as otherwise defined in this section, of a person or entity to which division (C)(2)(d)(i), (ii), (iii), or (iv) of this section applies, as if the person or entity were a person who claims an exemption;

(f) A managing agent of the person who claims an exemption.

(3) "Participant account" has the same meaning as in section 832
148.01 of the Revised Code. 833

(4) "Government unit" has the same meaning as in section 834
148.06 of the Revised Code. 835

(D) For purposes of this section, "interest" shall be 836
determined as follows: 837

(1) In bankruptcy proceedings, as of the date a petition is 838
filed with the bankruptcy court commencing a case under Title 11 839
of the United States Code; 840

(2) In all cases other than bankruptcy proceedings, as of the 841
date of an appraisal, if necessary under section 2329.68 of the 842
Revised Code, or the issuance of a writ of execution. 843

An interest, as determined under division (D)(1) or (2) of 844
this section, shall not include the amount of any lien otherwise 845
valid pursuant to section 2329.661 of the Revised Code. 846

Sec. 3769.21. (A) A corporation may be formed pursuant to 847
Chapter 1702. of the Revised Code to establish a thoroughbred 848
horsemen's health and retirement fund and a corporation may be 849
formed pursuant to Chapter 1702. of the Revised Code to establish 850
a harness horsemen's health and retirement fund to be administered 851
for the benefit of horsemen. As used in this section, "horsemen" 852
includes any person involved in the owning, breeding, training, 853
grooming, or racing of horses which race in Ohio, except for the 854
owners or managers of race tracks. For purposes of the 855
thoroughbred horsemen's health and retirement fund, "horsemen" 856
also does not include trainers and grooms who are not members of 857
the thoroughbred horsemen's organization in this state. No more 858
than one corporation to establish a thoroughbred horsemen's health 859
and retirement fund and no more than one corporation to establish 860
a harness horsemen's health and retirement fund may be established 861

in Ohio pursuant to this section. The trustees of the corporation 862
formed to establish a thoroughbred horsemen's health and 863
retirement fund shall have the discretion to determine which 864
horsemen shall benefit from such fund. 865

(B) The articles of incorporation of both of the corporations 866
described in division (A) of this section shall provide for at 867
least the following: 868

(1) The corporation shall be governed by, and the health and 869
retirement fund shall be administered by, a board of three 870
trustees appointed pursuant to division (C) of this section for 871
staggered three-year terms. 872

(2) The board of trustees shall adopt and administer a plan 873
to provide health benefits, retirement benefits, or both to either 874
thoroughbred or harness horsemen. 875

(3) The sum paid to the corporation pursuant to division (G) 876
or (H) of section 3769.08 of the Revised Code and the video 877
lottery terminal revenue paid to the corporation pursuant to 878
section 3769.087 of the Revised Code shall be used exclusively to 879
establish and administer the health and retirement fund, and to 880
finance benefits paid to horsemen pursuant to the plan adopted 881
under division (B)(2) of this section. 882

(4) The articles of incorporation and code of regulations of 883
the corporation may be amended at any time by the board of 884
trustees pursuant to the method set forth in the articles of 885
incorporation and code of regulations, except that no amendment 886
shall be adopted which is inconsistent with this section. 887

(C) Within sixty days after the formation of each of the 888
corporations described in division (A) of this section, the state 889
racing commission shall appoint the members of the board of 890
trustees of that corporation. Vacancies shall be filled by the 891
state racing commission in the same manner as initial 892

appointments. Each trustee of the thoroughbred horsemen's health 893
and retirement fund appointed by the commission shall be active as 894
a thoroughbred horseman while serving a term as a trustee and 895
shall have been active as a thoroughbred horseman for at least 896
five years immediately prior to the commencement of any such term. 897
Each trustee of the harness horsemen's health and retirement fund 898
appointed by the commission shall be active as a harness horseman 899
while serving a term as a trustee and shall have been active as a 900
harness horseman for at least five years immediately prior to the 901
commencement of any such term. The incorporators of either such 902
corporation may serve as initial trustees until the state racing 903
commission acts pursuant to this section to make these 904
appointments. 905

(D) The intent of the general assembly in enacting this 906
section pursuant to Amended House Bill No. 639 of the 115th 907
general assembly was to fulfill a legitimate government 908
responsibility in a manner that would be more cost efficient and 909
effective than direct state agency administration by permitting 910
nonprofit corporations to be formed to establish health and 911
retirement funds for the benefit of harness and thoroughbred 912
horsemen, as it was determined that such persons were in need of 913
such benefits. 914

Sec. 3923.022. (A) As used in this section: 915

(1)(a) "Administrative expense" means the amount resulting 916
from the following: the amount of premiums earned by the insurer 917
for sickness and accident insurance business plus the amount of 918
losses recovered from reinsurance coverage minus the sum of the 919
amount of claims for losses paid; the amount of losses incurred 920
but not reported; the amount incurred for state fees, federal and 921
state taxes, and reinsurance; and the incurred costs and expenses 922
related, either directly or indirectly, to the payment of 923

commissions, measures to control fraud, and managed care. 924

(b) "Administrative expense" does not include any amounts 925
collected, or administrative expenses incurred, by an insurer for 926
the administration of an employee health benefit plan subject to 927
regulation by the federal "Employee Retirement Income Security Act 928
of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. "Amounts 929
collected or administrative expenses incurred" means the total 930
amount paid to an administrator for the administration and payment 931
of claims minus the sum of the amount of claims for losses paid 932
and the amount of losses incurred but not reported. 933

(2) "Insurer" means any insurance company authorized under 934
Title XXXIX of the Revised Code to do the business of sickness and 935
accident insurance in this state. 936

(3) "Sickness and accident insurance business" does not 937
include coverage provided by an insurer for specific diseases or 938
accidents only; any hospital indemnity, medicare supplement, 939
long-term care, disability income, one-time-limited-duration 940
policy ~~of no longer than~~ that is less than six ~~twelve~~ months, or other 941
policy that offers only supplemental benefits; or coverage 942
provided to individuals who are not residents of this state. 943

(4) "Individual business" includes both individual sickness 944
and accident insurance and sickness and accident insurance made 945
available by insurers in the individual market to individuals, 946
with or without family members or dependents, through group 947
policies issued to one or more associations or entities. 948

(B) Notwithstanding section 3941.14 of the Revised Code, each 949
insurer shall have aggregate administrative expenses of no more 950
than twenty per cent of the premium income of the insurer, based 951
on the premiums earned in that year on the sickness and accident 952
insurance business of the insurer. 953

(C)(1) Each insurer, on the first day of January or within 954

sixty days thereafter, shall annually prepare, under oath, and
deposit in the office of the superintendent of insurance a
statement of the aggregate administrative expenses of the insurer,
based on the premiums earned in the immediately preceding calendar
year on the sickness and accident insurance business of the
insurer. The statement shall itemize and separately detail all of
the following information with respect to the insurer's sickness
and accident insurance business:

(a) The amount of premiums earned by the insurer both before
and after any costs related to the insurer's purchase of
reinsurance coverage;

(b) The total amount of claims for losses paid by the insurer
both before and after any reimbursement from reinsurance coverage;

(c) The amount of any losses incurred by the insurer but not
reported by the insurer in the current or prior year;

(d) The amount of costs incurred by the insurer for state
fees and federal and state taxes;

(e) The amount of costs incurred by the insurer for
reinsurance coverage;

(f) The amount of costs incurred by the insurer that are
related to the insurer's payment of commissions;

(g) The amount of costs incurred by the insurer that are
related to the insurer's fraud prevention measures;

(h) The amount of costs incurred by the insurer that are
related to managed care; and

(i) Any other administrative expenses incurred by the
insurer.

(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.	985
(D) No insurer shall fail to comply with this section.	986
(E) If the superintendent determines that an insurer has	987
violated this section, the superintendent, pursuant to an	988
adjudication conducted in accordance with Chapter 119. of the	989
Revised Code, may order the suspension of the insurer's license to	990
do the business of sickness and accident insurance in this state	991
until the superintendent is satisfied that the insurer is in	992
compliance with this section. If the insurer continues to do the	993
business of sickness and accident insurance in this state while	994
under the suspension order, the superintendent shall order the	995
insurer to pay one thousand dollars for each day of the violation.	996
(F) Any money collected by the superintendent under division	997
(E) of this section shall be deposited by the superintendent into	998
the state treasury to the credit of the department of insurance	999
operating fund.	1000
(G) The statement of aggregate expenses filed pursuant to	1001
this section separately detailing an insurer's individual, small	1002
group, and large group business shall be considered work papers	1003
resulting from the conduct of a market analysis of an entity	1004
subject to examination by the superintendent under division (C) of	1005
section 3901.48 of the Revised Code, except that the	1006
superintendent may share aggregated market information that	1007
identifies the premiums earned as reported under division	1008
(C)(1)(a) of this section, the administrative expenses reported	1009
under division (C)(1)(i) of this section, the amount of	1010
commissions reported under division (C)(1)(f) of this section, the	1011
amount of taxes paid as reported under division (C)(1)(d) of this	1012
section, the total of the remaining benefit costs as reported	1013
under divisions (C)(1)(b) and (c) of this section, and the amount	1014
of fraud and managed care expenses reported under divisions	1015
(C)(1)(g) and (h) of this section.	1016

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the Revised Code, every certificate furnished by an insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, and every multiple employer welfare arrangement offering an insurance program, which provides that coverage of an unmarried dependent child of a parent or legal guardian will terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance both of the following:

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

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

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

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

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

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a

dependent child if the child is and continues to be both of the 1047
following: 1048

(a) Incapable of self-sustaining employment by reason of 1049
mental retardation or physical handicap; 1050

(b) Primarily dependent upon the policyholder or certificate 1051
holder for support and maintenance. 1052

(B) Proof of such incapacity and dependence for purposes of 1053
division (A)(2) of this section shall be furnished by the 1054
policyholder or by the certificate holder to the insurer within 1055
thirty-one days of the child's attainment of the limiting age. 1056
Upon request, but not more frequently than annually after the 1057
two-year period following the child's attainment of the limiting 1058
age, the insurer may require proof satisfactory to it of the 1059
continuance of such incapacity and dependency. 1060

(C) Nothing in this section shall require an insurer to cover 1061
a dependent child who is mentally retarded or physically 1062
handicapped if the contract is underwritten on evidence of 1063
insurability based on health factors set forth in the application, 1064
or if such dependent child does not satisfy the conditions of the 1065
contract as to any requirement for evidence of insurability or 1066
other provision of the contract, satisfaction of which is required 1067
for coverage thereunder to take effect. In any such case, the 1068
terms of the contract shall apply with regard to the coverage or 1069
exclusion of the dependent from such coverage. Nothing in this 1070
section shall apply to accidental death or dismemberment benefits 1071
provided by any such policy of sickness and accident insurance. 1072

(D) Nothing in this section shall do any of the following: 1073

(1) Require that any policy offer coverage for dependent 1074
children or provide coverage for an unmarried dependent child's 1075
children as dependents on the policy; 1076

(2) Require an employer to pay for any part of the premium 1077

for an unmarried dependent child that has attained the limiting 1078
age for dependents, as provided in the policy; 1079

(3) Require an employer to offer health insurance coverage to 1080
the dependents of any employee. 1081

(E) This section does not apply to any policies or 1082
certificates covering only accident, credit, dental, disability 1083
income, long-term care, hospital indemnity, medicare supplement, 1084
specified disease, or vision care; coverage under a 1085
one-time-limited-duration policy ~~of not longer~~ that is less than 1086
~~six~~ twelve months; coverage issued as a supplement to liability 1087
insurance; insurance arising out of a workers' compensation or 1088
similar law; automobile medical-payment insurance; or insurance 1089
under which benefits are payable with or without regard to fault 1090
and that is statutorily required to be contained in any liability 1091
insurance policy or equivalent self-insurance. 1092

(F) As used in this section, "health benefit plan" has the 1093
same meaning as in section 3924.01 of the Revised Code and also 1094
includes both of the following: 1095

(1) A public employee benefit plan; 1096

(2) A health benefit plan as regulated under the "Employee 1097
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 1098

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the 1099
Revised Code, any public employee benefit plan that provides that 1100
coverage of an unmarried dependent child will terminate upon 1101
attainment of the limiting age for dependent children specified in 1102
the plan shall also provide in substance both of the following: 1103

(1) Once an unmarried child has attained the limiting age for 1104
dependent children, as provided in the plan, upon the request of 1105
the employee, the public employee benefit plan shall offer to 1106
cover the unmarried child until the child attains ~~twenty-eight~~ 1107

twenty-six years of age if all of the following are true: 1108

(a) The child is the natural child, stepchild, or adopted 1109
child of the employee. 1110

(b) The child is a resident of this state or a full-time 1111
student at an accredited public or private institution of higher 1112
education. 1113

(c) The child is not employed by an employer that offers any 1114
health benefit plan under which the child is eligible for 1115
coverage. 1116

(d) The child is not eligible for the medicaid program or the 1117
medicare program. 1118

(2) That attainment of the limiting age for dependent 1119
children shall not operate to terminate the coverage of a 1120
dependent child if the child is and continues to be both of the 1121
following: 1122

(a) Incapable of self-sustaining employment by reason of 1123
mental retardation or physical handicap; 1124

(b) Primarily dependent upon the plan member for support and 1125
maintenance. 1126

(B) Proof of incapacity and dependence for purposes of 1127
division (A)(2) of this section shall be furnished to the public 1128
employee benefit plan within thirty-one days of the child's 1129
attainment of the limiting age. Upon request, but not more 1130
frequently than annually, the public employee benefit plan may 1131
require proof satisfactory to it of the continuance of such 1132
incapacity and dependency. 1133

(C) Nothing in this section shall do any of the following: 1134

(1) Require that any public employee benefit plan offer 1135
coverage for dependent children or provide coverage for an 1136
unmarried dependent child's children as dependents on the public 1137

employee benefit plan;	1138
(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 plan;	1139 1140 1141
(3) Require an employer to offer health insurance coverage to the dependents of any employee.	1142 1143
(D) This section does not apply to any public employee benefit plan covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of not longer than <u>that is less than</u> six <u>twelve</u> months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.	1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154
(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:	1155 1156 1157
(1) A public employee benefit plan;	1158
(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.	1159 1160
Sec. 3923.281. (A) As used in this section:	1161
(1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American	1162 1163 1164 1165 1166 1167

psychiatric association. 1168

(2) "Policy of sickness and accident insurance" has the same 1169
meaning as in section 3923.01 of the Revised Code, but excludes 1170
any hospital indemnity, medicare supplement, long-term care, 1171
disability income, one-time-limited-duration policy ~~of not longer~~ 1172
that is less than ~~six~~ twelve months, supplemental benefit, or 1173
other policy that provides coverage for specific diseases or 1174
accidents only; any policy that provides coverage for workers' 1175
compensation claims compensable pursuant to Chapters 4121. and 1176
4123. of the Revised Code; and any policy that provides coverage 1177
to medicaid recipients. 1178

(B) Notwithstanding section 3901.71 of the Revised Code, and 1179
subject to division (E) of this section, every policy of sickness 1180
and accident insurance shall provide benefits for the diagnosis 1181
and treatment of biologically based mental illnesses on the same 1182
terms and conditions as, and shall provide benefits no less 1183
extensive than, those provided under the policy of sickness and 1184
accident insurance for the treatment and diagnosis of all other 1185
physical diseases and disorders, if both of the following apply: 1186

(1) The biologically based mental illness is clinically 1187
diagnosed by a physician authorized under Chapter 4731. of the 1188
Revised Code to practice medicine and surgery or osteopathic 1189
medicine and surgery; a psychologist licensed under Chapter 4732. 1190
of the Revised Code; a licensed professional clinical counselor, 1191
licensed professional counselor, independent social worker, or 1192
independent marriage and family therapist licensed under Chapter 1193
4757. of the Revised Code; or a clinical nurse specialist or 1194
certified nurse practitioner licensed under Chapter 4723. of the 1195
Revised Code whose nursing specialty is mental health. 1196

(2) The prescribed treatment is not experimental or 1197
investigational, having proven its clinical effectiveness in 1198
accordance with generally accepted medical standards. 1199

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

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions:

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

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

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

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

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

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental

illnesses for a period of at least six months independently caused 1231
the insurer's costs for claims and administrative expenses for the 1232
coverage of all other physical diseases and disorders to increase 1233
by more than one per cent per year. 1234

(2) The insurer submits a signed letter from an independent 1235
member of the American academy of actuaries to the superintendent 1236
of insurance opining that the increase described in division 1237
(E)(1) of this section could reasonably justify an increase of 1238
more than one per cent in the annual premiums or rates charged by 1239
the insurer for the coverage of all other physical diseases and 1240
disorders. 1241

(3) The superintendent of insurance makes the following 1242
determinations from the documentation and opinion submitted 1243
pursuant to divisions (E)(1) and (2) of this section: 1244

(a) Incurred claims for diagnostic and treatment services for 1245
biologically based mental illnesses for a period of at least six 1246
months independently caused the insurer's costs for claims and 1247
administrative expenses for the coverage of all other physical 1248
diseases and disorders to increase by more than one per cent per 1249
year. 1250

(b) The increase in costs reasonably justifies an increase of 1251
more than one per cent in the annual premiums or rates charged by 1252
the insurer for the coverage of all other physical diseases and 1253
disorders. 1254

Any determination made by the superintendent under this 1255
division is subject to Chapter 119. of the Revised Code. 1256

Sec. 3923.57. Notwithstanding any provision of this chapter, 1257
every individual policy of sickness and accident insurance that is 1258
delivered, issued for delivery, or renewed in this state is 1259
subject to the following conditions, as applicable: 1260

(A) Pre-existing conditions provisions shall not exclude or 1261
limit coverage for a period beyond twelve months following the 1262
policyholder's effective date of coverage and may only relate to 1263
conditions during the six months immediately preceding the 1264
effective date of coverage. 1265

(B) In determining whether a pre-existing conditions 1266
provision applies to a policyholder or dependent, each policy 1267
shall credit the time the policyholder or dependent was covered 1268
under a previous policy, contract, or plan if the previous 1269
coverage was continuous to a date not more than thirty days prior 1270
to the effective date of the new coverage, exclusive of any 1271
applicable service waiting period under the policy. 1272

(C)(1) Except as otherwise provided in division (C) of this 1273
section, an insurer that provides an individual sickness and 1274
accident insurance policy to an individual shall renew or continue 1275
in force such coverage at the option of the individual. 1276

(2) An insurer may nonrenew or discontinue coverage of an 1277
individual in the individual market based only on one or more of 1278
the following reasons: 1279

(a) The individual failed to pay premiums or contributions in 1280
accordance with the terms of the policy or the insurer has not 1281
received timely premium payments. 1282

(b) The individual performed an act or practice that 1283
constitutes fraud or made an intentional misrepresentation of 1284
material fact under the terms of the policy. 1285

(c) The insurer is ceasing to offer coverage in the 1286
individual market in accordance with division (D) of this section 1287
and the applicable laws of this state. 1288

(d) If the insurer offers coverage in the market through a 1289
network plan, the individual no longer resides, lives, or works in 1290
the service area, or in an area for which the insurer is 1291

authorized to do business; provided, however, that such coverage 1292
is terminated uniformly without regard to any health 1293
status-related factor of covered individuals. 1294

(e) If the coverage is made available in the individual 1295
market only through one or more bona fide associations, the 1296
membership of the individual in the association, on the basis of 1297
which the coverage is provided, ceases; provided, however, that 1298
such coverage is terminated under division (C)(2)(e) of this 1299
section uniformly without regard to any health status-related 1300
factor of covered individuals. 1301

An insurer offering coverage to individuals solely through 1302
membership in a bona fide association shall not be deemed, by 1303
virtue of that offering, to be in the individual market for 1304
purposes of sections 3923.58 and 3923.581 of the Revised Code. 1305
Such an insurer shall not be required to accept applicants for 1306
coverage in the individual market pursuant to sections 3923.58 and 1307
3923.581 of the Revised Code unless the insurer also offers 1308
coverage to individuals other than through bona fide associations. 1309

(3) An insurer may cancel or decide not to renew the coverage 1310
of a dependent of an individual if the dependent has performed an 1311
act or practice that constitutes fraud or made an intentional 1312
misrepresentation of material fact under the terms of the coverage 1313
and if the cancellation or nonrenewal is not based, either 1314
directly or indirectly, on any health status-related factor in 1315
relation to the dependent. 1316

(D)(1) If an insurer decides to discontinue offering a 1317
particular type of health insurance coverage offered in the 1318
individual market, coverage of such type may be discontinued by 1319
the insurer if the insurer does all of the following: 1320

(a) Provides notice to each individual provided coverage of 1321
this type in such market of the discontinuation at least ninety 1322

days prior to the date of the discontinuation of the coverage; 1323

(b) Offers to each individual provided coverage of this type 1324
in such market, the option to purchase any other individual health 1325
insurance coverage currently being offered by the insurer for 1326
individuals in that market; 1327

(c) In exercising the option to discontinue coverage of this 1328
type and in offering the option of coverage under division 1329
(D)(1)(b) of this section, acts uniformly without regard to any 1330
health status-related factor of covered individuals or of 1331
individuals who may become eligible for such coverage. 1332

(2) If an insurer elects to discontinue offering all health 1333
insurance coverage in the individual market in this state, health 1334
insurance coverage may be discontinued by the insurer only if both 1335
of the following apply: 1336

(a) The insurer provides notice to the department of 1337
insurance and to each individual of the discontinuation at least 1338
one hundred eighty days prior to the date of the expiration of the 1339
coverage. 1340

(b) All health insurance delivered or issued for delivery in 1341
this state in such market is discontinued and coverage under that 1342
health insurance in that market is not renewed. 1343

(3) In the event of a discontinuation under division (D)(2) 1344
of this section in the individual market, the insurer shall not 1345
provide for the issuance of any health insurance coverage in the 1346
market and this state during the five-year period beginning on the 1347
date of the discontinuation of the last health insurance coverage 1348
not so renewed. 1349

(E) Notwithstanding divisions (C) and (D) of this section, an 1350
insurer may, at the time of coverage renewal, modify the health 1351
insurance coverage for a policy form offered to individuals in the 1352
individual market if the modification is consistent with the law 1353

of this state and effective on a uniform basis among all 1354
individuals with that policy form. 1355

(F) Such policies are subject to sections 2743 and 2747 of 1356
the "Health Insurance Portability and Accountability Act of 1996," 1357
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 1358
300gg-47, as amended. 1359

(G) Sections 3924.031 and 3924.032 of the Revised Code shall 1360
apply to sickness and accident insurance policies offered in the 1361
individual market in the same manner as they apply to health 1362
benefit plans offered in the small employer market. 1363

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of 1364
this section also apply to all group sickness and accident 1365
insurance policies that are not sold in connection with an 1366
employment-related group health plan and that provide more than 1367
short-term, limited duration coverage. 1368

In applying divisions (C) to (G) of this section with respect 1369
to health insurance coverage that is made available by an insurer 1370
in the individual market to individuals only through one or more 1371
associations, the term "individual" includes the association of 1372
which the individual is a member. 1373

For purposes of this section, any policy issued pursuant to 1374
division (C) of section 3923.13 of the Revised Code in connection 1375
with a public or private college or university student health 1376
insurance program is considered to be issued to a bona fide 1377
association. 1378

As used in this section, "bona fide association" has the same 1379
meaning as in section 3924.03 of the Revised Code, and "health 1380
status-related factor" and "network plan" have the same meanings 1381
as in section 3924.031 of the Revised Code. 1382

This section does not apply to any policy that provides 1383
coverage for specific diseases or accidents only, or to any 1384

hospital indemnity, medicare supplement, long-term care, 1385
disability income, one-time-limited-duration policy ~~of no longer~~ 1386
that is less than ~~six~~ twelve months, or other policy that offers 1387
only supplemental benefits. 1388

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 1389
the Revised Code: 1390

(1) "Base rate" means, as to any health benefit plan that is 1391
issued by a carrier in the individual market, the lowest premium 1392
rate for new or existing business prescribed by the carrier for 1393
the same or similar coverage under a plan or arrangement covering 1394
any individual with similar case characteristics. 1395

(2) "Carrier," "health benefit plan," and "MEWA" have the 1396
same meanings as in section 3924.01 of the Revised Code. 1397

(3) "Network plan" means a health benefit plan of a carrier 1398
under which the financing and delivery of medical care, including 1399
items and services paid for as medical care, are provided, in 1400
whole or in part, through a defined set of providers under 1401
contract with the carrier. 1402

(4) "Ohio health care basic and standard plans" means those 1403
plans established under section 3924.10 of the Revised Code. 1404

(5) "Pre-existing conditions provision" means a policy 1405
provision that excludes or limits coverage for charges or expenses 1406
incurred during a specified period following the insured's 1407
effective date of coverage as to a condition which, during a 1408
specified period immediately preceding the effective date of 1409
coverage, had manifested itself in such a manner as would cause an 1410
ordinarily prudent person to seek medical advice, diagnosis, care, 1411
or treatment or for which medical advice, diagnosis, care, or 1412
treatment was recommended or received, or a pregnancy existing on 1413
the effective date of coverage. 1414

(B) Beginning in January of each year, carriers in the 1415
business of issuing health benefit plans to individuals and 1416
nonemployer groups, except individual health benefit plans issued 1417
pursuant to sections 1751.16 and 3923.122 of the Revised Code, 1418
shall accept applicants for open enrollment coverage, as set forth 1419
in this division, in the order in which they apply for coverage 1420
and subject to the limitation set forth in division (G) of this 1421
section. Carriers shall accept for coverage pursuant to this 1422
section individuals to whom both of the following conditions 1423
apply: 1424

(1) The individual is not applying for coverage as an 1425
employee of an employer, as a member of an association, or as a 1426
member of any other group. 1427

(2) The individual is not covered, and is not eligible for 1428
coverage, under any other private or public health benefits 1429
arrangement, including the medicare program established under 1430
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 1431
U.S.C.A. 301, as amended, or any other act of congress or law of 1432
this or any other state of the United States that provides 1433
benefits comparable to the benefits provided under this section, 1434
any medicare supplement policy, or any continuation of coverage 1435
policy under state or federal law. 1436

(C) A carrier shall offer to any individual accepted under 1437
this section the Ohio health care basic and standard plans or 1438
health benefit plans that are substantially similar to the Ohio 1439
health care basic and standard plans in benefit plan design and 1440
scope of covered services. 1441

A carrier may offer other health benefit plans in addition 1442
to, but not in lieu of, the plans required to be offered under 1443
this division. A basic health benefit plan shall provide, at a 1444
minimum, the coverage provided by the Ohio health care basic plan 1445
or any health benefit plan that is substantially similar to the 1446

Ohio health care basic plan in benefit plan design and scope of 1447
covered services. A standard health benefit plan shall provide, at 1448
a minimum, the coverage provided by the Ohio health care standard 1449
plan or any health benefit plan that is substantially similar to 1450
the Ohio health care standard plan in benefit plan design and 1451
scope of covered services. 1452

For purposes of this division, the superintendent of 1453
insurance shall determine whether a health benefit plan is 1454
substantially similar to the Ohio health care basic and standard 1455
plans in benefit plan design and scope of covered services. 1456

(D)(1) Health benefit plans issued under this section may 1457
establish pre-existing conditions provisions that exclude or limit 1458
coverage for a period of up to twelve months following the 1459
individual's effective date of coverage and that may relate only 1460
to conditions during the six months immediately preceding the 1461
effective date of coverage. A health insuring corporation may 1462
apply a pre-existing condition provision for any basic health care 1463
service related to a transplant of a body organ if the transplant 1464
occurs within one year after the effective date of an enrollee's 1465
coverage under this section except with respect to a newly born 1466
child who meets the requirements for coverage under section 1467
1751.61 of the Revised Code. 1468

(2) In determining whether a pre-existing conditions 1469
provision applies to an insured or dependent, each policy shall 1470
credit the time the insured or dependent was covered under a 1471
previous policy, contract, or plan if the previous coverage was 1472
continuous to a date not more than sixty-three days prior to the 1473
effective date of the new coverage, exclusive of any applicable 1474
service waiting period under the policy. 1475

(E) Premiums charged to individuals under this section may 1476
not exceed the amounts specified below: 1477

(1) For calendar years 2010 and 2011, an amount that is two 1478
times the base rate for coverage offered to any other individual 1479
to which the carrier is currently accepting new business, and for 1480
which similar copayments and deductibles are applied; 1481

(2) For calendar year 2012 and every year thereafter, an 1482
amount that is one and one-half times the base rate for coverage 1483
offered to any other individual to which the carrier is currently 1484
accepting new business and for which similar copayments and 1485
deductibles are applied, unless the superintendent of insurance 1486
determines that the amendments by this act to this section and 1487
section 3923.581 of the Revised Code, have resulted in the 1488
market-wide average medical loss ratio for coverage sold to 1489
individual insureds and nonemployer group insureds in this state, 1490
including open enrollment insureds, to increase by more than five 1491
and one quarter percentage points during calendar year 2010. If 1492
the superintendent makes that determination, the premium limit 1493
established by division (E)(1) of this section shall remain in 1494
effect. The superintendent's determination shall be supported by a 1495
signed letter from a member of the American academy of actuaries. 1496

(F) In offering health benefit plans under this section, a 1497
carrier may require the purchase of health benefit plans that 1498
condition the reimbursement of health services upon the use of a 1499
specific network of providers. 1500

(G)(1) A carrier shall not be required to accept new 1501
applicants under this section if the total number of the carrier's 1502
current insureds with open enrollment coverage issued under this 1503
section calculated as of the immediately preceding thirty-first 1504
day of December and excluding the carrier's medicare supplement 1505
policies and conversion or continuation of coverage policies under 1506
state or federal law and any policies described in division (L) of 1507
this section meets the following limits: 1508

(a) For calendar years 2010 and 2011, four per cent of the 1509

carrier's total number of individual or nonemployer group insureds 1510
in this state; 1511

(b) For calendar year 2012 and every year thereafter, eight 1512
per cent of the carrier's total number of insured individuals and 1513
nonemployer group insureds in this state, unless the 1514
superintendent of insurance determines that the amendments by this 1515
act to this section and section 3923.581 of the Revised Code, have 1516
resulted in the market-wide average medical loss ratio for 1517
coverage sold to individual insureds and nonemployer group 1518
insureds in this state, including open enrollment insureds, to 1519
increase by more than five and one quarter percentage points 1520
during calendar year 2010. If the superintendent makes that 1521
determination, the enrollment limit established by division 1522
(G)(1)(a) of this section shall remain in effect. The 1523
superintendent's determination shall be supported by a signed 1524
letter from a member of the American academy of actuaries. 1525

(2) An officer of the carrier shall certify to the department 1526
of insurance when it has met the enrollment limit set forth in 1527
division (G)(1) of this section. Upon providing such 1528
certification, the carrier shall be relieved of its open 1529
enrollment requirement under this section as long as the carrier 1530
continues to meet the open enrollment limit. If the total number 1531
of the carrier's current insureds with open enrollment coverage 1532
issued under this section falls below the enrollment limit, the 1533
carrier shall accept new applicants. A carrier may establish a 1534
waiting list if the carrier has met the open enrollment limit and 1535
shall notify the superintendent if the carrier has a waiting list 1536
in effect. 1537

(H) A carrier shall not be required to accept under this 1538
section applicants who, at the time of enrollment, are confined to 1539
a health care facility because of chronic illness, permanent 1540
injury, or other infirmity that would cause economic impairment to 1541

the carrier if the applicants were accepted. A carrier shall not 1542
be required to make the effective date of benefits for individuals 1543
accepted under this section earlier than ninety days after the 1544
date of acceptance, except that when the individual had prior 1545
coverage with a health benefit plan that was terminated by a 1546
carrier because the carrier exited the market and the individual 1547
was accepted for open enrollment under this section within 1548
sixty-three days of that termination, the effective date of 1549
benefits shall be the date of enrollment. 1550

(I) The requirements of this section do not apply to any 1551
carrier that is currently in a state of supervision, insolvency, 1552
or liquidation. If a carrier demonstrates to the satisfaction of 1553
the superintendent that the requirements of this section would 1554
place the carrier in a state of supervision, insolvency, or 1555
liquidation, or would otherwise jeopardize the carrier's economic 1556
viability overall or in the individual market, the superintendent 1557
may waive or modify the requirements of division (B) or (G) of 1558
this section. The actions of the superintendent under this 1559
division shall be effective for a period of not more than one 1560
year. At the expiration of such time, a new showing of need for a 1561
waiver or modification by the carrier shall be made before a new 1562
waiver or modification is issued or imposed. 1563

(J) No hospital, health care facility, or health care 1564
practitioner, and no person who employs any health care 1565
practitioner, shall balance bill any individual or dependent of an 1566
individual for any health care supplies or services provided to 1567
the individual or dependent who is insured under a policy issued 1568
under this section. The hospital, health care facility, or health 1569
care practitioner, or any person that employs the health care 1570
practitioner, shall accept payments made to it by the carrier 1571
under the terms of the policy or contract insuring or covering 1572
such individual as payment in full for such health care supplies 1573

or services. 1574

As used in this division, "hospital" has the same meaning as 1575
in section 3727.01 of the Revised Code; "health care practitioner" 1576
has the same meaning as in section 4769.01 of the Revised Code; 1577
and "balance bill" means charging or collecting an amount in 1578
excess of the amount reimbursable or payable under the policy or 1579
health care service contract issued to an individual under this 1580
section for such health care supply or service. "Balance bill" 1581
does not include charging for or collecting copayments or 1582
deductibles required by the policy or contract. 1583

(K) A carrier may pay an agent a commission in the amount of 1584
not more than five per cent of the premium charged for initial 1585
placement or for otherwise securing the issuance of a policy or 1586
contract issued to an individual under this section, and not more 1587
than four per cent of the premium charged for the renewal of such 1588
a policy or contract. The superintendent may adopt, in accordance 1589
with Chapter 119. of the Revised Code, such rules as are necessary 1590
to enforce this division. 1591

(L) This section does not apply to any policy that provides 1592
coverage for specific diseases or accidents only, or to any 1593
hospital indemnity, medicare supplement, long-term care, 1594
disability income, one-time-limited-duration policy ~~of no longer~~ 1595
that is less than ~~six~~ twelve months, or other policy that offers 1596
only supplemental benefits. 1597

(M) If a carrier offers a health benefit plan in the 1598
individual market through a network plan, the carrier may do both 1599
of the following: 1600

(1) Limit the individuals that may apply for such coverage to 1601
those who live, work, or reside in the service area of the network 1602
plan; 1603

(2) Within the service area of the network plan, deny the 1604

coverage to individuals if the carrier has demonstrated both of 1605
the following to the superintendent: 1606

(a) The carrier will not have the capacity to deliver 1607
services adequately to any additional individuals because of the 1608
carrier's obligations to existing group contract holders and 1609
individuals. 1610

(b) The carrier is applying division (M)(2) of this section 1611
uniformly to all individuals without regard to any health 1612
status-related factors of those individuals. 1613

(N) A carrier that, pursuant to division (M)(2) of this 1614
section, denies coverage to an individual in the service area of a 1615
network plan, shall not offer coverage in the individual market 1616
within that service area for at least one hundred eighty days 1617
after the date the carrier denies the coverage. 1618

Sec. 3923.601. (A)(1) This section applies to both of the 1619
following: 1620

(a) A sickness and accident insurer that issues or requires 1621
the use of a standardized identification card or an electronic 1622
technology for submission and routing of prescription drug claims 1623
pursuant to a policy, contract, or agreement for health care 1624
services; 1625

(b) A person that a sickness and accident insurer contracts 1626
with to issue a standardized identification card or an electronic 1627
technology described in division (A)(1)(a) of this section. 1628

(2) Notwithstanding division (A)(1) of this section, this 1629
section does not apply to the issuance or required use of a 1630
standardized identification card or an electronic technology for 1631
the submission and routing of prescription drug claims in 1632
connection with any of the following: 1633

(a) Any individual or group policy of sickness and accident 1634

insurance covering only accident, credit, dental, disability 1635
income, long-term care, hospital indemnity, medicare supplement, 1636
medicare, tricare, specified disease, or vision care; coverage 1637
under a one-time-limited-duration policy ~~of not longer~~ that is 1638
less than ~~six~~ twelve months; coverage issued as a supplement to 1639
liability insurance; insurance arising out of workers' 1640
compensation or similar law; automobile medical payment insurance; 1641
or insurance under which benefits are payable with or without 1642
regard to fault and which is statutorily required to be contained 1643
in any liability insurance policy or equivalent self-insurance. 1644

(b) Coverage provided under the medicaid program. 1645

(c) Coverage provided under an employer's self-insurance plan 1646
or by any of its administrators, as defined in section 3959.01 of 1647
the Revised Code, to the extent that federal law supersedes, 1648
preempts, prohibits, or otherwise precludes the application of 1649
this section to the plan and its administrators. 1650

(B) A standardized identification card or an electronic 1651
technology issued or required to be used as provided in division 1652
(A)(1) of this section shall contain uniform prescription drug 1653
information in accordance with either division (B)(1) or (2) of 1654
this section. 1655

(1) The standardized identification card or the electronic 1656
technology shall be in a format and contain information fields 1657
approved by the national council for prescription drug programs or 1658
a successor organization, as specified in the council's or 1659
successor organization's pharmacy identification card 1660
implementation guide in effect on the first day of October most 1661
immediately preceding the issuance or required use of the 1662
standardized identification card or the electronic technology. 1663

(2) If the insurer or person under contract with the insurer 1664
to issue a standardized identification card or an electronic 1665

technology requires the information for the submission and routing 1666
of a claim, the standardized identification card or the electronic 1667
technology shall contain any of the following information: 1668

(a) The insurer's name; 1669

(b) The insured's name, group number, and identification 1670
number; 1671

(c) A telephone number to inquire about pharmacy-related 1672
issues; 1673

(d) The issuer's international identification number, labeled 1674
as "ANSI BIN" or "RxBIN"; 1675

(e) The processor's control number, labeled as "RxPCN"; 1676

(f) The insured's pharmacy benefits group number if different 1677
from the insured's medical group number, labeled as "RxGrp." 1678

(C) If the standardized identification card or the electronic 1679
technology issued or required to be used as provided in division 1680
(A)(1) of this section is also used for submission and routing of 1681
nonpharmacy claims, the designation "Rx" is required to be 1682
included as part of the labels identified in divisions (B)(2)(d) 1683
and (e) of this section if the issuer's international 1684
identification number or the processor's control number is 1685
different for medical and pharmacy claims. 1686

(D) Each sickness and accident insurer described in division 1687
(A) of this section shall annually file a certificate with the 1688
superintendent of insurance certifying that it or any person it 1689
contracts with to issue a standardized identification card or 1690
electronic technology for submission and routing of prescription 1691
drug claims complies with this section. 1692

(E)(1) Except as provided in division (E)(2) of this section, 1693
if there is a change in the information contained in the 1694
standardized identification card or the electronic technology 1695

issued to an insured, the insurer or person under contract with 1696
the insurer to issue a standardized identification card or an 1697
electronic technology shall issue a new card or electronic 1698
technology to the insured. 1699

(2) An insurer or person under contract with the insurer is 1700
not required under division (E)(1) of this section to issue a new 1701
card or electronic technology to an insured more than once during 1702
a twelve-month period. 1703

(F) Nothing in this section shall be construed as requiring 1704
an insurer to produce more than one standardized identification 1705
card or one electronic technology for use by insureds accessing 1706
health care benefits provided under a policy of sickness and 1707
accident insurance. 1708

Sec. 3923.65. (A) As used in this section: 1709

(1) "Emergency medical condition" means a medical condition 1710
that manifests itself by such acute symptoms of sufficient 1711
severity, including severe pain, that a prudent layperson with 1712
average knowledge of health and medicine could reasonably expect 1713
the absence of immediate medical attention to result in any of the 1714
following: 1715

(a) Placing the health of the individual or, with respect to 1716
a pregnant woman, the health of the woman or her unborn child, in 1717
serious jeopardy; 1718

(b) Serious impairment to bodily functions; 1719

(c) Serious dysfunction of any bodily organ or part. 1720

(2) "Emergency services" means the following: 1721

(a) A medical screening examination, as required by federal 1722
law, that is within the capability of the emergency department of 1723
a hospital, including ancillary services routinely available to 1724
the emergency department, to evaluate an emergency medical 1725

condition; 1726

(b) Such further medical examination and treatment that are 1727
required by federal law to stabilize an emergency medical 1728
condition and are within the capabilities of the staff and 1729
facilities available at the hospital, including any trauma and 1730
burn center of the hospital. 1731

(B) Every individual or group policy of sickness and accident 1732
insurance that provides hospital, surgical, or medical expense 1733
coverage shall cover emergency services without regard to the day 1734
or time the emergency services are rendered or to whether the 1735
policyholder, the hospital's emergency department where the 1736
services are rendered, or an emergency physician treating the 1737
policyholder, obtained prior authorization for the emergency 1738
services. 1739

(C) Every individual policy or certificate furnished by an 1740
insurer in connection with any sickness and accident insurance 1741
policy shall provide information regarding the following: 1742

(1) The scope of coverage for emergency services; 1743

(2) The appropriate use of emergency services, including the 1744
use of the 9-1-1 system and any other telephone access systems 1745
utilized to access prehospital emergency services; 1746

(3) Any copayments for emergency services. 1747

(D) This section does not apply to any individual or group 1748
policy of sickness and accident insurance covering only accident, 1749
credit, dental, disability income, long-term care, hospital 1750
indemnity, medicare supplement, medicare, tricare, specified 1751
disease, or vision care; coverage under a one-time limited 1752
duration policy ~~of no longer~~ that is less than six ~~twelve~~ months; 1753
coverage issued as a supplement to liability insurance; insurance 1754
arising out of workers' compensation or similar law; automobile 1755
medical payment insurance; or insurance under which benefits are 1756

payable with or without regard to fault and which is statutorily 1757
required to be contained in any liability insurance policy or 1758
equivalent self-insurance. 1759

Sec. 3923.83. (A)(1) This section applies to both of the 1760
following: 1761

(a) A public employee benefit plan that issues or requires 1762
the use of a standardized identification card or an electronic 1763
technology for submission and routing of prescription drug claims 1764
pursuant to a policy, contract, or agreement for health care 1765
services; 1766

(b) A person or entity that a public employee benefit plan 1767
contracts with to issue a standardized identification card or an 1768
electronic technology described in division (A)(1)(a) of this 1769
section. 1770

(2) Notwithstanding division (A)(1) of this section, this 1771
section does not apply to the issuance or required use of a 1772
standardized identification card or an electronic technology for 1773
the submission and routing of prescription drug claims in 1774
connection with either of the following: 1775

(a) Any individual or group policy of insurance covering only 1776
accident, credit, dental, disability income, long-term care, 1777
hospital indemnity, medicare supplement, medicare, tricare, 1778
specified disease, or vision care; coverage under a 1779
one-time-limited-duration policy ~~of not longer~~ that is less than 1780
~~six~~ twelve months; coverage issued as a supplement to liability 1781
insurance; insurance arising out of workers' compensation or 1782
similar law; automobile medical payment insurance; or insurance 1783
under which benefits are payable with or without regard to fault 1784
and which is statutorily required to be contained in any liability 1785
insurance policy or equivalent self-insurance. 1786

(b) Coverage provided under the medicaid program.	1787
(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.	1788 1789 1790 1791 1792
(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.	1793 1794 1795 1796 1797 1798 1799 1800
(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:	1801 1802 1803 1804 1805 1806
(a) The plan's name;	1807
(b) The insured's name, group number, and identification number;	1808 1809
(c) A telephone number to inquire about pharmacy-related issues;	1810 1811
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	1812 1813
(e) The processor's control number, labeled as "RxPCN";	1814
(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."	1815 1816

(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.

(D)(1) Except as provided in division (D)(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 public employee benefit plan or person under contract with the plan to issue a standardized identification card or electronic technology shall issue a new card or electronic technology to the insured.

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

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

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

(B) Notwithstanding section 3901.71 of the Revised Code and

subject to division (D) of this section, no individual or group 1848
policy of sickness and accident insurance that is delivered, 1849
issued for delivery, or renewed in this state and no public 1850
employee benefit plan that is established or modified in this 1851
state shall fail to comply with either of the following: 1852

(1) The policy or plan shall not provide coverage or impose 1853
cost sharing for a prescribed, orally administered cancer 1854
medication on a less favorable basis than the coverage it provides 1855
or cost sharing it imposes for intravenously administered or 1856
injected cancer medications. 1857

(2) The policy or plan shall not comply with division (B)(1) 1858
of this section by imposing an increase in cost sharing solely for 1859
orally administered, intravenously administered, or injected 1860
cancer medications. 1861

(C) Notwithstanding any provision of this section to the 1862
contrary, a policy or plan shall be deemed to be in compliance 1863
with this section if the cost sharing imposed under such a policy 1864
or plan for orally administered cancer treatments does not exceed 1865
one hundred dollars per prescription fill. The cost sharing limit 1866
of one hundred dollars per prescription fill shall apply to a high 1867
deductible plan, as defined in 26 U.S.C. 223, or a catastrophic 1868
plan, as defined in 42 U.S.C. 18022, only after the deductible has 1869
been met. 1870

(D)(1) The prohibitions in division (B) of this section do 1871
not preclude an individual or group policy of sickness and 1872
accident insurance or public employee benefit plan from requiring 1873
an insured or plan member to obtain prior authorization before 1874
orally administered cancer medication is dispensed to the insured 1875
or plan member. 1876

(2) Division (B) of this section does not apply to the offer 1877
or renewal of any individual or group policy of sickness and 1878

accident insurance that provides coverage for specific diseases or 1879
accidents only, or to any hospital indemnity, medicare supplement, 1880
disability income, or other policy that offers only supplemental 1881
benefits. 1882

(E) An insurer that offers any sickness and accident 1883
insurance or any public employee benefit plan that offers coverage 1884
for basic health care services is not required to comply with 1885
division (B) of this section if all of the following apply: 1886

(1) The insurer or plan submits documentation certified by an 1887
independent member of the American academy of actuaries to the 1888
superintendent of insurance showing that compliance with division 1889
(B)(1) of this section for a period of at least six months 1890
independently caused the insurer or plan's costs for claims and 1891
administrative expenses for the coverage of basic health care 1892
services to increase by more than one per cent per year. 1893

(2) The insurer or plan submits a signed letter from an 1894
independent member of the American academy of actuaries to the 1895
superintendent of insurance opining that the increase in costs 1896
described in division (E)(1) of this section could reasonably 1897
justify an increase of more than one per cent in the annual 1898
premiums or rates charged by the insurer or plan for the coverage 1899
of basic health care services. 1900

(3)(a) The superintendent of insurance makes the following 1901
determinations from the documentation and opinion submitted 1902
pursuant to divisions (E)(1) and (2) of this section: 1903

(i) Compliance with division (B)(1) of this section for a 1904
period of at least six months independently caused the insurer or 1905
plan's costs for claims and administrative expenses for the 1906
coverage of basic health care services to increase more than one 1907
per cent per year. 1908

(ii) The increase in costs reasonably justifies an increase 1909

of more than one per cent in the annual premiums or rates charged 1910
by the insurer or plan for the coverage of basic health care 1911
services. 1912

(b) Any determination made by the superintendent under 1913
division (E)(3) of this section is subject to Chapter 119. of the 1914
Revised Code. 1915

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the 1916
Revised Code: 1917

(A) "Actuarial certification" means a written statement 1918
prepared by a member of the American academy of actuaries, or by 1919
any other person acceptable to the superintendent of insurance, 1920
that states that, based upon the person's examination, a carrier 1921
offering health benefit plans to small employers is in compliance 1922
with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial 1923
certification" shall include a review of the appropriate records 1924
of, and the actuarial assumptions and methods used by, the carrier 1925
relative to establishing premium rates for the health benefit 1926
plans. 1927

(B) "Adjusted average market premium price" means the average 1928
market premium price as determined by the board of directors of 1929
the Ohio health reinsurance program either on the basis of the 1930
arithmetic mean of all carriers' premium rates for an OHC plan 1931
sold to groups with similar case characteristics by all carriers 1932
selling OHC plans in the state, or on any other equitable basis 1933
determined by the board. 1934

(C) "Base premium rate" means, as to any health benefit plan 1935
that is issued by a carrier and that covers at least two but no 1936
more than fifty employees of a small employer, the lowest premium 1937
rate for a new or existing business prescribed by the carrier for 1938
the same or similar coverage under a plan or arrangement covering 1939
any small employer with similar case characteristics. 1940

(D) "Carrier" means any sickness and accident insurance 1941
company or health insuring corporation authorized to issue health 1942
benefit plans in this state or a MEWA. A sickness and accident 1943
insurance company that owns or operates a health insuring 1944
corporation, either as a separate corporation or as a line of 1945
business, shall be considered as a separate carrier from that 1946
health insuring corporation for purposes of sections 3924.01 to 1947
3924.14 of the Revised Code. 1948

(E) "Case characteristics" means, with respect to a small 1949
employer, the geographic area in which the employees work; the age 1950
and sex of the individual employees and their dependents; the 1951
appropriate industry classification as determined by the carrier; 1952
the number of employees and dependents; and such other objective 1953
criteria as may be established by the carrier. "Case 1954
characteristics" does not include claims experience, health 1955
status, or duration of coverage from the date of issue. 1956

(F) "Dependent" means the spouse or child of an eligible 1957
employee, subject to applicable terms of the health benefits plan 1958
covering the employee. 1959

(G) "Eligible employee" means an employee who works a normal 1960
work week of ~~twenty-five~~ thirty or more hours. "Eligible employee" 1961
does not include a temporary or substitute employee, or a seasonal 1962
employee who works only part of the calendar year on the basis of 1963
natural or suitable times or circumstances. 1964

(H) "Health benefit plan" means any hospital or medical 1965
expense policy or certificate or any health plan provided by a 1966
carrier, that is delivered, issued for delivery, renewed, or used 1967
in this state on or after the date occurring six months after 1968
November 24, 1995. "Health benefit plan" does not include policies 1969
covering only accident, credit, dental, disability income, 1970
long-term care, hospital indemnity, medicare supplement, specified 1971
disease, or vision care; coverage under a 1972

one-time-limited-duration policy ~~of no longer~~ that is less than 1973
~~six~~ twelve months; coverage issued as a supplement to liability 1974
insurance; insurance arising out of a workers' compensation or 1975
similar law; automobile medical-payment insurance; or insurance 1976
under which benefits are payable with or without regard to fault 1977
and which is statutorily required to be contained in any liability 1978
insurance policy or equivalent self-insurance. 1979

(I) "Late enrollee" means an eligible employee or dependent 1980
who enrolls in a small employer's health benefit plan other than 1981
during the first period in which the employee or dependent is 1982
eligible to enroll under the plan or during a special enrollment 1983
period described in section 2701(f) of the "Health Insurance 1984
Portability and Accountability Act of 1996," Pub. L. No. 104-191, 1985
110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 1986

(J) "MEWA" means any "multiple employer welfare arrangement" 1987
as defined in section 3 of the "Federal Employee Retirement Income 1988
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 1989
except for any arrangement which is fully insured as defined in 1990
division (b)(6)(D) of section 514 of that act. 1991

(K) "Midpoint rate" means, for small employers with similar 1992
case characteristics and plan designs and as determined by the 1993
applicable carrier for a rating period, the arithmetic average of 1994
the applicable base premium rate and the corresponding highest 1995
premium rate. 1996

(L) "Pre-existing conditions provision" means a policy 1997
provision that excludes or limits coverage for charges or expenses 1998
incurred during a specified period following the insured's 1999
enrollment date as to a condition for which medical advice, 2000
diagnosis, care, or treatment was recommended or received during a 2001
specified period immediately preceding the enrollment date. 2002
Genetic information shall not be treated as such a condition in 2003
the absence of a diagnosis of the condition related to such 2004

information. 2005

For purposes of this division, "enrollment date" means, with 2006
respect to an individual covered under a group health benefit 2007
plan, the date of enrollment of the individual in the plan or, if 2008
earlier, the first day of the waiting period for such enrollment. 2009

(M) "Service waiting period" means the period of time after 2010
employment begins before an employee is eligible to be covered for 2011
benefits under the terms of any applicable health benefit plan 2012
offered by the small employer. 2013

(N)(1) "Small employer" means, in connection with a group 2014
health benefit plan and with respect to a calendar year and a plan 2015
year, an employer who employed an average of at least two but no 2016
more than fifty eligible employees on business days during the 2017
preceding calendar year and who employs at least two employees on 2018
the first day of the plan year. 2019

(2) For purposes of division (N)(1) of this section, all 2020
persons treated as a single employer under subsection (b), (c), 2021
(m), or (o) of section 414 of the "Internal Revenue Code of 1986," 2022
100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one 2023
employer. In the case of an employer that was not in existence 2024
throughout the preceding calendar year, the determination of 2025
whether the employer is a small or large employer shall be based 2026
on the average number of eligible employees that it is reasonably 2027
expected the employer will employ on business days in the current 2028
calendar year. Any reference in division (N) of this section to an 2029
"employer" includes any predecessor of the employer. Except as 2030
otherwise specifically provided, provisions of sections 3924.01 to 2031
3924.14 of the Revised Code that apply to a small employer that 2032
has a health benefit plan shall continue to apply until the plan 2033
anniversary following the date the employer no longer meets the 2034
requirements of this division. 2035

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

Sec. 4729.291. (A) When a licensed health professional authorized to prescribe drugs personally furnishes drugs to a patient pursuant to division (B) of section 4729.29 of the Revised Code, the prescriber shall ensure that the drugs are labeled and packaged in accordance with state and federal drug laws and any rules and regulations adopted pursuant to those laws. Records of purchase and disposition of all drugs personally furnished to patients shall be maintained by the prescriber in accordance with state and federal drug statutes and any rules adopted pursuant to those statutes.

(B) When personally furnishing to a patient RU-486 (mifepristone), a prescriber is subject to section 2919.123 of the Revised Code. A prescription for RU-486 (mifepristone) shall be in writing and in accordance with section 2919.123 of the Revised Code.

(C)(1) Except as provided in division (D) of this section, a no prescriber ~~may not~~ shall do either of the following:

(a) In any thirty-day period, personally furnish to or for patients, taken as a whole, controlled substances in an amount that exceeds a total of two thousand five hundred dosage units;

(b) In any seventy-two-hour period, personally furnish to or for a patient an amount of a controlled substance that exceeds the amount necessary for the patient's use in a seventy-two-hour period.

(2) The state board of pharmacy may impose a fine of not more than five thousand dollars on a prescriber who fails to comply

with the limits established under division (C)(1) of this section. 2066
A separate fine may be imposed for each instance of failing to 2067
comply with the limits. In imposing the fine, the board's actions 2068
shall be taken in accordance with Chapter 119. of the Revised 2069
Code. 2070

(D)(1) None of the following shall be counted in determining 2071
whether the amounts specified in division (C)(1) of this section 2072
have been exceeded: 2073

(a) Methadone provided to patients for the purpose of 2074
treating drug dependence or addiction, if the prescriber meets the 2075
conditions specified in 21 C.F.R. 1306.07; 2076

(b) Buprenorphine provided to patients for the purpose of 2077
treating drug dependence or addiction, ~~if the prescriber is exempt~~ 2078
~~from separate registration with the United States drug enforcement~~ 2079
~~administration as part of an opioid treatment program that is the~~ 2080
subject of a current, valid certification from the substance abuse 2081
and mental health services administration of the United States 2082
department of health and human services pursuant to ~~21~~ 42 C.F.R. 2083
~~1301.28~~ 8.11 and distributes both buprenorphine and methadone; 2084

(c) Controlled substances provided to research subjects by a 2085
facility conducting clinical research in studies approved by a 2086
hospital-based institutional review board or an institutional 2087
review board accredited by the association for the accreditation 2088
of human research protection programs. 2089

(2) Division (C)(1) of this section does not apply to a 2090
prescriber who is a veterinarian. 2091

Sec. 4729.541. (A) Except as provided in divisions (B) and 2092
(C) of this section, a business entity described in division 2093
(B)(1)(j) or (k) of section 4729.51 of the Revised Code may 2094
possess, have custody or control of, and distribute the dangerous 2095

drugs in category I, category II, and category III, as defined in 2096
section 4729.54 of the Revised Code, without holding a terminal 2097
distributor of dangerous drugs license issued under that section. 2098

(B) If a business entity described in division (B)(1)(j) or 2099
(k) of section 4729.51 of the Revised Code is a pain management 2100
clinic or is operating a pain management clinic, the entity shall 2101
hold a license as a terminal distributor of dangerous drugs with a 2102
pain management clinic classification issued under section 2103
4729.552 of the Revised Code. 2104

(C) Beginning April 1, 2015, a business entity described in 2105
division (B)(1)(j) or (k) of section 4729.51 of the Revised Code 2106
shall hold a license as a terminal distributor of dangerous drugs 2107
in order to possess, have custody or control of, and distribute 2108
~~dangerous~~ either of the following: 2109

(1) Dangerous drugs that are compounded or used for the 2110
purpose of compounding; 2111

(2) Controlled substances containing buprenorphine that are 2112
used for the purpose of treating drug dependence or addiction. 2113

Sec. 4731.056. (A) As used in this section: 2114

(1) "Controlled substance," "schedule III," "schedule IV," 2115
and "schedule V" have the same meanings as in section 3719.01 of 2116
the Revised Code. 2117

(2) "Physician" means an individual authorized by this 2118
chapter to practice medicine and surgery or osteopathic medicine 2119
and surgery. 2120

(B) The state medical board shall adopt rules in accordance 2121
with Chapter 119. of the Revised Code that establish standards and 2122
procedures to be followed by physicians in the use of controlled 2123
substances in schedule III, IV, or V to treat opioid dependence or 2124

addiction. The board may limit the application of the rules to 2125
treatment provided through an office-based practice or other 2126
practice type or location specified by the board. 2127

Section 2. That existing sections 1739.061, 1751.14, 1751.69, 2128
2329.66, 3769.21, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 2129
3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, 2130
and 4729.541 of the Revised Code are hereby repealed. 2131

Section 3. (A) Not later than thirty days after the effective 2132
date of this section, the legislative authority of the fund member 2133
described in section 143.02 of the Revised Code, as enacted by 2134
this act, that maintains the police or sheriff's department shall 2135
hold the initial election of members to a volunteer peace officers 2136
dependents' fund board. A board member shall serve an initial term 2137
of office beginning on the day after the member is elected to the 2138
board and ending on the thirty-first day of December of the year 2139
in which the member is elected. Thereafter, members shall be 2140
elected to the board and serve terms of office in accordance with 2141
section 143.02 of the Revised Code, as enacted by this act. 2142

(B) For the initial election of board members specified in 2143
division (A)(2) of section 143.02 of the Revised Code, the 2144
legislative authority of the fund member that maintains the police 2145
or sheriff's department shall do both of the following: 2146

(1) Give notice of the election by posting it in a 2147
conspicuous place at the headquarters of the police or sheriff's 2148
department. Between nine a.m. and nine p.m. on the day designated, 2149
each person eligible to vote shall send in writing the name of two 2150
persons eligible to be elected to the board who are the person's 2151
choices. 2152

(2) Count and record all votes cast at the election and 2153
announce the result. The two persons receiving the highest number 2154

of votes are elected. If there is a tie vote for any two persons, 2155
the election shall be decided by lot or in any other way agreed on 2156
by the persons for whom the tie vote was cast. 2157

Section 4. This act shall have no impact on the Public 2158
Employees Retirement System, Ohio Police and Fire Pension Fund, or 2159
State Highway Patrol Retirement System. 2160

Section 5. Section 1751.14 and division (G) of section 2161
3924.01 of the Revised Code, as amended by this act, apply only to 2162
policies, contracts, and agreements that are delivered, issued for 2163
delivery, or renewed in this state on or after January 1, 2016. 2164
Division (A)(1) of section 3923.24 and division (A)(1) of section 2165
3923.241 of the Revised Code, as amended by this act, apply only 2166
to policies of sickness and accident insurance delivered, issued 2167
for delivery, or renewed in this state and public employee benefit 2168
plans or multiple employer welfare arrangement contracts and 2169
certificates that are established or modified in this state on or 2170
after January 1, 2016. 2171

Section 6. The General Assembly declares that the amendments 2172
made to section 3923.58 of the Revised Code by this act are not to 2173
supersede the suspension of the operation of this section enacted 2174
by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, 2175
it is the intent of the General Assembly to ensure consistency in 2176
Ohio Insurance Law should this suspension be nullified. 2177

Section 7. Section 2329.66 of the Revised Code is presented 2178
in this act as a composite of the section as amended by both Sub. 2179
H.B. 479 and Sub. S.B. 343 of the 129th General Assembly. The 2180
General Assembly, applying the principle stated in division (B) of 2181
section 1.52 of the Revised Code that amendments are to be 2182
harmonized if reasonably capable of simultaneous operation, finds 2183
that the composite is the resulting version of the section in 2184

effect prior to the effective date of the section as presented in 2185
this act. 2186