

As Reported by the House Health and Aging Committee

130th General Assembly

Regular Session

2013-2014

Sub. S. B. No. 288

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**

—

A B I L L

To amend sections 1739.061, 1751.14, 1751.69, 1
2329.66, 3923.022, 3923.24, 3923.241, 3923.281, 2
3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3
3923.85, 3924.01, 4729.291, and 4729.541 and to 4
enact sections 143.01 to 143.11, 505.377, 737.082, 5
737.222, and 4731.056 of the Revised Code to 6
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, and 20

to establish requirements regarding controlled 21
substances containing buprenorphine used for the 22
purpose of treating drug dependence or addiction. 23

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

Section 1. That sections 1739.061, 1751.14, 1751.69, 2329.66, 24
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 25
3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 be 26
amended and sections 143.01, 143.02, 143.03, 143.04, 143.05, 27
143.06, 143.07, 143.08, 143.09, 143.10, 143.11, 505.377, 737.082, 28
737.222, and 4731.056 of the Revised Code be enacted to read as 29
follows: 30

Sec. 143.01. As used in this chapter: 31

(A) "Killed in the line of duty" means either of the 32
following: 33

(1) Death in the line of duty; 34

(2) Death from injury sustained in the line of duty, 35
including heart attack or other fatal injury or illness caused 36
while in the line of duty. 37

(B) "Totally and permanently disabled" means unable to engage 38
in any substantial gainful employment for a period of not less 39
than twelve months by reason of a medically determinable physical 40
impairment that is permanent or presumed to be permanent. 41

(C) "Volunteer peace officer" means any person who is 42
employed as a police officer, sheriff's deputy, constable, or 43
deputy marshal in a part-time, reserve, or volunteer capacity by a 44
county sheriff's department or the police department of a 45
municipal corporation, township, township police district, or 46
joint police district and is not a member of the public employees 47

retirement system, Ohio police and fire pension fund, state 48
highway patrol retirement system, or the Cincinnati retirement 49
system. 50

Sec. 143.02. (A) There is hereby established the volunteer 51
peace officers dependents fund. 52

Each county, municipal corporation, township, township police 53
district, and joint police district with a police or sheriff's 54
department that employs volunteer peace officers is a member of 55
the volunteer peace officers' dependents fund and shall establish 56
a volunteer peace officers' dependents fund board. Each board 57
shall consist of the following board members: 58

(1) Two board members, elected by the legislative authority 59
of the fund member that maintains the police or sheriff's 60
department; 61

(2) Two board members, elected by the volunteer peace 62
officers of the police or sheriff's department; 63

(3) One board member, elected by the board members elected 64
pursuant to divisions (A)(1) and (2) of this section. The board 65
member must be an elector of the fund member in which the police 66
or sheriff's department is located, but not a public employee, 67
member of the legislative authority, or peace officer of that 68
peace or sheriff's department. 69

(B) The term of office of a board member begins the first day 70
of January and is one year. 71

(C)(1) The election of the board members specified in 72
division (A)(1) of this section shall be held each year not 73
earlier than the first day of November and not later than the 74
second Monday in December. The election of the member specified in 75
division (A)(3) of this section shall be held each year on or 76
before the thirty-first day of December. 77

(2) The members specified in division (A)(2) of this section shall be elected on or before the second Monday in December, as follows: 78
79
80

(a) The secretary of the board shall give notice of the election by posting it in a conspicuous place at the headquarters of the police or sheriff's department. Between nine a.m. and nine p.m. on the day designated, each person eligible to vote shall send in writing the name of two persons eligible to be elected to the board who are the person's choices. 81
82
83
84
85
86

(b) All votes cast at the election shall be counted and recorded by the board, which shall announce the result. The two persons receiving the highest number of votes are elected. If there is a tie vote for any two persons, the election shall be decided by lot or in any other way agreed on by the persons for whom the tie vote was cast. 87
88
89
90
91
92

(D) Any vacancy occurring on a board shall be filled at a special election called by the board's secretary. 93
94

Sec. 143.03. A volunteer peace officers' dependents fund board shall meet promptly after election of the board's members and organize. The board shall select from among its members a chairperson and a secretary. 95
96
97
98

The secretary of the board shall keep a complete record of the board's proceedings, which shall be maintained as a permanent file. 99
100
101

Board members shall serve without compensation. 102

The legislative authority of the fund member shall provide sufficient meeting space and supplies for the board to carry out its duties. 103
104
105

The secretary shall submit all of the following to the director of commerce: 106
107

<u>(A) The name and address of each board member and an</u>	108
<u>indication of the group or authority that elected the member;</u>	109
<u>(B) The names of the chairperson and secretary;</u>	110
<u>(C) A certificate indicating the current assessed property</u>	111
<u>valuation of the fund member that is prepared by the clerk of the</u>	112
<u>fund member.</u>	113
<u>Sec. 143.04. Each volunteer peace officers' dependents fund</u>	114
<u>board may adopt rules as necessary for handling and processing</u>	115
<u>claims for benefits.</u>	116
<u>The board shall perform such other duties as are necessary to</u>	117
<u>implement this chapter.</u>	118
<u>Sec. 143.05. The prosecuting attorney of the county in which</u>	119
<u>a fund member is located shall serve as the legal advisor for the</u>	120
<u>volunteer peace officer's dependents' board.</u>	121
<u>Sec. 143.06. (A) The volunteer peace officers' dependents</u>	122
<u>fund shall be maintained in the state treasury. All investment</u>	123
<u>earnings of the fund shall be collected by the treasurer of state</u>	124
<u>and placed to the credit of the fund.</u>	125
<u>(B) Each fund member shall pay to the treasurer of state, to</u>	126
<u>the credit of the fund, an initial premium as follows:</u>	127
<u>(1) Each member with an assessed property valuation of less</u>	128
<u>than seven million dollars, three hundred dollars;</u>	129
<u>(2) Each member with an assessed property valuation of seven</u>	130
<u>million dollars but less than fourteen million dollars, three</u>	131
<u>hundred fifty dollars;</u>	132
<u>(3) Each member with an assessed property valuation of</u>	133
<u>fourteen million dollars but less than twenty-one million dollars,</u>	134
<u>four hundred dollars;</u>	135

(4) Each member with an assessed property valuation of 136
twenty-one million dollars but less than twenty-eight million 137
dollars, four hundred fifty dollars; 138

(5) Each member with an assessed property valuation of 139
twenty-eight million dollars or over, five hundred dollars. 140

Sec. 143.07. The total of all initial premiums collected by 141
the treasurer of state under section 143.06 of the Revised Code is 142
the basic capital account of the volunteer peace officers' 143
dependents fund. No further contributions are required of fund 144
members until claims against the fund have reduced it to 145
ninety-five per cent or less of its basic capital account. In that 146
event, the director of commerce shall cause the following 147
assessments, based on current property valuation, to be made and 148
certified to the legislative authority of each member of the fund: 149

(A) Each member with an assessed property valuation of less 150
than seven million dollars, ninety dollars; 151

(B) Each member with an assessed property valuation of seven 152
million dollars but less than fourteen million dollars, one 153
hundred five dollars; 154

(C) Each member with an assessed property valuation of 155
fourteen million dollars but less than twenty-one million dollars, 156
one hundred twenty dollars; 157

(D) Each member with an assessed property valuation of 158
twenty-one million dollars but less than twenty-eight million 159
dollars, one hundred thirty-five dollars; 160

(E) Each member with an assessed property valuation of 161
twenty-eight million dollars or more, one hundred fifty dollars. 162

Sec. 143.08. (A) If a premium is not paid as provided in 163
section 143.06 of the Revised Code, the director of commerce shall 164

certify the failure as an assessment against the fund member to 165
the auditor of the county within which the member is located. The 166
county auditor shall withhold the amount of the assessment, 167
together with interest at the rate of six per cent from the due 168
date of the premium, from the next ensuing tax settlement due the 169
member and pay the amount to the treasurer of state to the credit 170
of the volunteer peace officers' dependents fund. 171

If the secretary of a volunteer peace officers' dependents 172
fund board fails to submit to the director a certificate of the 173
current assessed property valuation in accordance with section 174
143.03 of the Revised Code, the director shall use division (B)(5) 175
of section 143.06 of the Revised Code as a basis for the 176
assessment. 177

(B) If a fund member does not pay the assessment provided in 178
section 143.07 of the Revised Code within forty-five days after 179
notice, the director shall proceed with collection in accordance 180
with division (A) of this section. 181

Sec. 143.09. (A) A volunteer peace officer who is totally and 182
permanently disabled as a result of discharging the duties of a 183
volunteer peace officer shall receive a benefit from the volunteer 184
peace officers' dependents fund of three hundred dollars per 185
month, except that no payment shall be made to a volunteer peace 186
officer who is receiving the officer's full salary during the time 187
of the officer's disability. 188

(B) Regardless of whether the volunteer peace officer 189
received a benefit under division (A) of this section, death 190
benefits shall be paid from the fund to the surviving spouse or 191
dependent children of a volunteer peace officer who is killed in 192
the line of duty. Death benefits shall be paid as follows: 193

(1) To the surviving spouse of a volunteer peace officer 194

killed in the line of duty, an award of one thousand dollars, and 195
in addition, a benefit of three hundred dollars per month; 196

(2) To the parent, guardian, or other persons on whom a child 197
of a volunteer peace officer killed in the line of duty is 198
dependent for chief financial support, a benefit of one hundred 199
twenty-five dollars per month for each dependent child under age 200
eighteen, or under age twenty-two if attending an institution of 201
learning or training pursuant to a program designed to complete in 202
each school year the equivalent of at least two-thirds of the 203
full-time curriculum requirements of the institution. 204

(C) An individual eligible for benefits payable under this 205
section shall file a claim for benefits with the appropriate 206
volunteer peace officers' dependents fund board on a form provided 207
by the board. All of the following information shall be submitted 208
with the claim: 209

(1) In the case of a totally and permanently disabled 210
volunteer peace officer, the following: 211

(a) The name of the police or sheriff's department for which 212
the officer was a volunteer peace officer; 213

(b) The date of the injury; 214

(c) Satisfactory medical evidence that the officer is totally 215
and permanently disabled. 216

(2) In the case of a surviving spouse or a parent, guardian, 217
or other person in charge of a dependent child, the following: 218

(a) The full name of the deceased volunteer peace officer; 219

(b) The name of the police or sheriff's department for which 220
the deceased officer was a volunteer peace officer; 221

(c) The name and address of the surviving spouse, as 222
applicable; 223

(d) The names, ages, and addresses of any dependent children; 224

(e) Any other evidence required by the board. 225

(D) All claimants shall certify that neither the claimant nor the person on whose behalf the claim is filed qualifies for other benefits from any of the following based on the officer's service as a volunteer peace officer: the public employees retirement system, Ohio police and fire pension fund, state highway patrol retirement system, Cincinnati retirement system, or Ohio public safety officers death benefit fund. 226
227
228
229
230
231
232

(E) Initial claims shall be filed with the volunteer peace officers' dependents fund board of the fund member in which the officer was a volunteer peace officer. Thereafter, on request of the claimant or the board, claims may be transferred to a board near the claimant's current residence, if the boards concerned agree to the transfer. 233
234
235
236
237
238

Sec. 143.10. (A)(1) Not later than five days after receipt of a claim for benefits, a volunteer peace officers' dependents fund board shall meet and determine the validity of the claim. If the board determines that the claim is valid, it shall make a determination of the amount due and certify its determination to the director of commerce for payment. The certificate shall show the name and address of the board, the name and address of each beneficiary, the amount to be received by or on behalf of each beneficiary, and the name and address of the person to whom payments are to be made. 239
240
241
242
243
244
245
246
247
248

(2) If the board determines that a claimant is ineligible for benefits, the board shall deny the claim and issue to the claimant a copy of its order. 249
250
251

(B) The board may make a continuing order for monthly payments to a claimant for a period not exceeding three months from the date of the determination. The determination may be modified after issuance to reflect any changes in the claimant's 252
253
254
255

eligibility. If no changes occur at the end of the three-month 256
period, the director may provide for payment if the board 257
certifies that the original certificate is continued for an 258
additional three-month period. 259

Sec. 143.11. The right of an individual to a benefit under 260
this chapter shall not be subject to execution, garnishment, 261
attachment, the operation of bankruptcy or insolvency laws, or 262
other process of law whatsoever, and shall be unassignable except 263
as specifically provided in this chapter and sections 3105.171, 264
3105.65, and 3115.32 and Chapters 3119., 3121., 3123., and 3125. 265
of the Revised Code. 266

Sec. 505.377. A volunteer firefighter appointed pursuant to 267
this chapter is a bona fide volunteer and not an employee for 268
purposes of section 513 of the "Patient Protection and Affordable 269
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 270
providing those fire protection services, the volunteer receives 271
any of the benefits provided in Chapter 146., 4121., or 4123. or 272
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 273
Code. 274

Sec. 737.082. A volunteer firefighter appointed pursuant to 275
this chapter is a bona fide volunteer and not an employee for 276
purposes of section 513 of the "Patient Protection and Affordable 277
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 278
providing those fire protection services, the volunteer receives 279
any of the benefits provided in Chapter 146., 4121., or 4123. or 280
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 281
Code. 282

Sec. 737.222. A volunteer firefighter appointed pursuant to 283
this chapter is a bona fide volunteer and not an employee for 284

purposes of section 513 of the "Patient Protection and Affordable 285
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 286
providing those fire protection services, the volunteer receives 287
any of the benefits provided in Chapter 146., 4121., or 4123. or 288
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 289
Code. 290

Sec. 1739.061. (A)(1) This section applies to both of the 291
following: 292

(a) A multiple employer welfare arrangement that issues or 293
requires the use of a standardized identification card or an 294
electronic technology for submission and routing of prescription 295
drug claims; 296

(b) A person or entity that a multiple employer welfare 297
arrangement contracts with to issue a standardized identification 298
card or an electronic technology described in division (A)(1)(a) 299
of this section. 300

(2) Notwithstanding division (A)(1) of this section, this 301
section does not apply to the issuance or required use of a 302
standardized identification card or an electronic technology for 303
the submission and routing of prescription drug claims in 304
connection with any of the following: 305

(a) Any program or arrangement covering only accident, 306
credit, dental, disability income, long-term care, hospital 307
indemnity, medicare supplement, medicare, tricare, specified 308
disease, or vision care; coverage under a 309
one-time-limited-duration policy ~~of not longer~~ that is less than 310
~~six~~ twelve months; coverage issued as a supplement to liability 311
insurance; insurance arising out of workers' compensation or 312
similar law; automobile medical payment insurance; or insurance 313
under which benefits are payable with or without regard to fault 314

and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 315
316

(b) Coverage provided under the medicaid program. 317

(c) Coverage provided under an employer's self-insurance plan 318
or by any of its administrators, as defined in section 3959.01 of 319
the Revised Code, to the extent that federal law supersedes, 320
preempts, prohibits, or otherwise precludes the application of 321
this section to the plan and its administrators. 322

(B) A standardized identification card or an electronic 323
technology issued or required to be used as provided in division 324
(A)(1) of this section shall contain uniform prescription drug 325
information in accordance with either division (B)(1) or (2) of 326
this section. 327

(1) The standardized identification card or the electronic 328
technology shall be in a format and contain information fields 329
approved by the national council for prescription drug programs or 330
a successor organization, as specified in the council's or 331
successor organization's pharmacy identification card 332
implementation guide in effect on the first day of October most 333
immediately preceding the issuance or required use of the 334
standardized identification card or the electronic technology. 335

(2) If the multiple employer welfare arrangement or person 336
under contract with it to issue a standardized identification card 337
or an electronic technology requires the information for the 338
submission and routing of a claim, the standardized identification 339
card or the electronic technology shall contain any of the 340
following information: 341

(a) The name of the multiple employer welfare arrangement; 342

(b) The individual's name, group number, and identification 343
number; 344

(c) A telephone number to inquire about pharmacy-related issues;	345 346
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	347 348
(e) The processor's control number, labeled as "RxPCN";	349
(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."	350 351 352
(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.	353 354 355 356 357 358 359 360
(D) Each multiple employer welfare arrangement described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section.	361 362 363 364 365 366
(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an individual, the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the individual.	367 368 369 370 371 372 373
(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this	374 375

section to issue a new card or electronic technology to an 376
individual more than once during a twelve-month period. 377

(F) Nothing in this section shall be construed as requiring a 378
multiple employer welfare arrangement to produce more than one 379
standardized identification card or one electronic technology for 380
use by individuals accessing health care benefits provided under a 381
multiple employer welfare arrangement. 382

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the 383
Revised Code, any policy, contract, or agreement for health care 384
services authorized by this chapter that is issued, delivered, or 385
renewed in this state and that provides that coverage of an 386
unmarried dependent child will terminate upon attainment of the 387
limiting age for dependent children specified in the policy, 388
contract, or agreement, shall also provide in substance both of 389
the following: 390

(1) Once an unmarried child has attained the limiting age for 391
dependent children, as provided in the policy, contract, or 392
agreement, upon the request of the subscriber, the health insuring 393
corporation shall offer to cover the unmarried child until the 394
child attains ~~twenty-eight~~ twenty-six years of age if all of the 395
following are true: 396

(a) The child is the natural child, stepchild, or adopted 397
child of the subscriber. 398

(b) The child is a resident of this state or a full-time 399
student at an accredited public or private institution of higher 400
education. 401

(c) The child is not employed by an employer that offers any 402
health benefit plan under which the child is eligible for 403
coverage. 404

(d) The child is not eligible for coverage under the medicaid 405

program or the medicare program. 406

(2) That attainment of the limiting age for dependent 407
children shall not operate to terminate the coverage of a 408
dependent child if the child is and continues to be both of the 409
following: 410

(a) Incapable of self-sustaining employment by reason of 411
mental retardation or physical handicap; 412

(b) Primarily dependent upon the subscriber for support and 413
maintenance. 414

(B) Proof of incapacity and dependence for purposes of 415
division (A)(2) of this section shall be furnished to the health 416
insuring corporation within thirty-one days of the child's 417
attainment of the limiting age. Upon request, but not more 418
frequently than annually, the health insuring corporation may 419
require proof satisfactory to it of the continuance of such 420
incapacity and dependency. 421

(C) Nothing in this section shall do any of the following: 422

(1) Require that any policy, contract, or agreement offer 423
coverage for dependent children or provide coverage for an 424
unmarried dependent child's children as dependents on the policy, 425
contract, or agreement; 426

(2) Require an employer to pay for any part of the premium 427
for an unmarried dependent child that has attained the limiting 428
age for dependents, as provided in the policy, contract, or 429
agreement; 430

(3) Require an employer to offer health insurance coverage to 431
the dependents of any employee. 432

(D) This section does not apply to any health insuring 433
corporation policy, contract, or agreement offering only 434
supplemental health care services or specialty health care 435

services. 436

(E) As used in this section, "health benefit plan" has the 437
same meaning as in section 3924.01 of the Revised Code and also 438
includes both of the following: 439

(1) A public employee benefit plan; 440

(2) A health benefit plan as regulated under the "Employee 441
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 442

Sec. 1751.69. (A) As used in this section, "cost sharing" 443
means the cost to an individual insured under an individual or 444
group health insuring corporation policy, contract, or agreement 445
according to any coverage limit, copayment, coinsurance, 446
deductible, or other out-of-pocket expense requirements imposed by 447
the policy, contract, or agreement. 448

(B) Notwithstanding section 3901.71 of the Revised Code and 449
subject to division (D) of this section, no individual or group 450
health insuring corporation policy, contract, or agreement 451
providing basic health care services or prescription drug services 452
that is delivered, issued for delivery, or renewed in this state, 453
if the policy, contract, or agreement provides coverage for cancer 454
chemotherapy treatment, shall fail to comply with either of the 455
following: 456

(1) The policy, contract, or agreement shall not provide 457
coverage or impose cost sharing for a prescribed, orally 458
administered cancer medication on a less favorable basis than the 459
coverage it provides or cost sharing it imposes for intravenously 460
administered or injected cancer medications. 461

(2) The policy, contract, or agreement shall not comply with 462
division (B)(1) of this section by imposing an increase in cost 463
sharing solely for orally administered, intravenously 464
administered, or injected cancer medications. 465

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

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

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

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

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

the coverage of basic health care services. 498

(3)(a) The superintendent of insurance makes the following 499
determinations from the documentation and opinion submitted 500
pursuant to divisions (E)(1) and (2) of this section: 501

(i) Compliance with division (B)(1) of this section for a 502
period of at least six months independently caused the health 503
insuring corporation's costs for claims and administrative 504
expenses for the coverage of basic health care services to 505
increase more than one per cent per year. 506

(ii) The increase in costs reasonably justifies an increase 507
of more than one per cent in the annual premiums or rates charged 508
by the health insuring corporation for the coverage of basic 509
health care services. 510

(b) Any determination made by the superintendent under 511
division (E)(3) of this section is subject to Chapter 119. of the 512
Revised Code. 513

Sec. 2329.66. (A) Every person who is domiciled in this state 514
may hold property exempt from execution, garnishment, attachment, 515
or sale to satisfy a judgment or order, as follows: 516

(1)(a) In the case of a judgment or order regarding money 517
owed for health care services rendered or health care supplies 518
provided to the person or a dependent of the person, one parcel or 519
item of real or personal property that the person or a dependent 520
of the person uses as a residence. Division (A)(1)(a) of this 521
section does not preclude, affect, or invalidate the creation 522
under this chapter of a judgment lien upon the exempted property 523
but only delays the enforcement of the lien until the property is 524
sold or otherwise transferred by the owner or in accordance with 525
other applicable laws to a person or entity other than the 526
surviving spouse or surviving minor children of the judgment 527

debtor. Every person who is domiciled in this state may hold 528
exempt from a judgment lien created pursuant to division (A)(1)(a) 529
of this section the person's interest, not to exceed one hundred 530
twenty-five thousand dollars, in the exempted property. 531

(b) In the case of all other judgments and orders, the 532
person's interest, not to exceed one hundred twenty-five thousand 533
dollars, in one parcel or item of real or personal property that 534
the person or a dependent of the person uses as a residence. 535

(c) For purposes of divisions (A)(1)(a) and (b) of this 536
section, "parcel" means a tract of real property as identified on 537
the records of the auditor of the county in which the real 538
property is located. 539

(2) The person's interest, not to exceed three thousand two 540
hundred twenty-five dollars, in one motor vehicle; 541

(3) The person's interest, not to exceed four hundred 542
dollars, in cash on hand, money due and payable, money to become 543
due within ninety days, tax refunds, and money on deposit with a 544
bank, savings and loan association, credit union, public utility, 545
landlord, or other person, other than personal earnings. 546

(4)(a) The person's interest, not to exceed five hundred 547
twenty-five dollars in any particular item or ten thousand seven 548
hundred seventy-five dollars in aggregate value, in household 549
furnishings, household goods, wearing apparel, appliances, books, 550
animals, crops, musical instruments, firearms, and hunting and 551
fishing equipment that are held primarily for the personal, 552
family, or household use of the person; 553

(b) The person's aggregate interest in one or more items of 554
jewelry, not to exceed one thousand three hundred fifty dollars, 555
held primarily for the personal, family, or household use of the 556
person or any of the person's dependents. 557

(5) The person's interest, not to exceed an aggregate of two 558

thousand twenty-five dollars, in all implements, professional	559
books, or tools of the person's profession, trade, or business,	560
including agriculture;	561
(6)(a) The person's interest in a beneficiary fund set apart,	562
appropriated, or paid by a benevolent association or society, as	563
exempted by section 2329.63 of the Revised Code;	564
(b) The person's interest in contracts of life or endowment	565
insurance or annuities, as exempted by section 3911.10 of the	566
Revised Code;	567
(c) The person's interest in a policy of group insurance or	568
the proceeds of a policy of group insurance, as exempted by	569
section 3917.05 of the Revised Code;	570
(d) The person's interest in money, benefits, charity,	571
relief, or aid to be paid, provided, or rendered by a fraternal	572
benefit society, as exempted by section 3921.18 of the Revised	573
Code;	574
(e) The person's interest in the portion of benefits under	575
policies of sickness and accident insurance and in lump sum	576
payments for dismemberment and other losses insured under those	577
policies, as exempted by section 3923.19 of the Revised Code.	578
(7) The person's professionally prescribed or medically	579
necessary health aids;	580
(8) The person's interest in a burial lot, including, but not	581
limited to, exemptions under section 517.09 or 1721.07 of the	582
Revised Code;	583
(9) The person's interest in the following:	584
(a) Moneys paid or payable for living maintenance or rights,	585
as exempted by section 3304.19 of the Revised Code;	586
(b) Workers' compensation, as exempted by section 4123.67 of	587
the Revised Code;	588

(c) Unemployment compensation benefits, as exempted by section 4141.32 of the Revised Code;	589 590
(d) Cash assistance payments under the Ohio works first program, as exempted by section 5107.75 of the Revised Code;	591 592
(e) Benefits and services under the prevention, retention, and contingency program, as exempted by section 5108.08 of the Revised Code;	593 594 595
(f) Disability financial assistance payments, as exempted by section 5115.06 of the Revised Code;	596 597
(g) Payments under section 24 or 32 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.	598 599
(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 accumulated contributions, the person's rights to or interests in a participant account in any deferred compensation program offered by the Ohio public employees deferred compensation board, a government unit, or a municipal corporation, or the person's other accrued or accruing rights or interests, as exempted by section <u>143.11</u> , 145.56, 146.13, 148.09, 742.47, 3307.41, 3309.66, or 5505.22 of the Revised Code, and the person's rights to or	600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619

interests in benefits from the Ohio public safety officers death benefit fund; 620
621

(b) Except as provided in sections 3119.80, 3119.81, 3121.02, 622
3121.03, and 3123.06 of the Revised Code, the person's rights to 623
receive or interests in receiving a payment or other benefits 624
under any pension, annuity, or similar plan or contract, not 625
including a payment or benefit from a stock bonus or 626
profit-sharing plan or a payment included in division (A)(6)(b) or 627
(10)(a) of this section, on account of illness, disability, death, 628
age, or length of service, to the extent reasonably necessary for 629
the support of the person and any of the person's dependents, 630
except if all the following apply: 631

(i) The plan or contract was established by or under the 632
auspices of an insider that employed the person at the time the 633
person's rights or interests under the plan or contract arose. 634

(ii) The payment is on account of age or length of service. 635

(iii) The plan or contract is not qualified under the 636
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as 637
amended. 638

(c) Except for any portion of the assets that were deposited 639
for the purpose of evading the payment of any debt and except as 640
provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 641
3123.06 of the Revised Code, the person's rights or interests in 642
the assets held in, or to directly or indirectly receive any 643
payment or benefit under, any individual retirement account, 644
individual retirement annuity, "Roth IRA," "529 plan," or 645
education individual retirement account that provides payments or 646
benefits by reason of illness, disability, death, retirement, or 647
age or provides payments or benefits for purposes of education, to 648
the extent that the assets, payments, or benefits described in 649
division (A)(10)(c) of this section are attributable to or derived 650

from any of the following or from any earnings, dividends, 651
interest, appreciation, or gains on any of the following: 652

(i) Contributions of the person that were less than or equal 653
to the applicable limits on deductible contributions to an 654
individual retirement account or individual retirement annuity in 655
the year that the contributions were made, whether or not the 656
person was eligible to deduct the contributions on the person's 657
federal tax return for the year in which the contributions were 658
made; 659

(ii) Contributions of the person that were less than or equal 660
to the applicable limits on contributions to a Roth IRA or 661
education individual retirement account in the year that the 662
contributions were made; 663

(iii) Contributions of the person that are within the 664
applicable limits on rollover contributions under subsections 219, 665
402(c), 403(a)(4), 403(b)(8), 408(b), 408(d)(3), 408A(c)(3)(B), 666
408A(d)(3), and 530(d)(5) of the "Internal Revenue Code of 1986," 667
100 Stat. 2085, 26 U.S.C.A. 1, as amended; 668

(iv) Contributions by any person into any plan, fund, or 669
account that is formed, created, or administered pursuant to, or 670
is otherwise subject to, section 529 of the "Internal Revenue Code 671
of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended. 672

(d) Except for any portion of the assets that were deposited 673
for the purpose of evading the payment of any debt and except as 674
provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 675
3123.06 of the Revised Code, the person's rights or interests in 676
the assets held in, or to receive any payment under, any Keogh or 677
"H.R. 10" plan that provides benefits by reason of illness, 678
disability, death, retirement, or age, to the extent reasonably 679
necessary for the support of the person and any of the person's 680
dependents. 681

(e) The person's rights to or interests in any assets held 682
in, or to directly or indirectly receive any payment or benefit 683
under, any individual retirement account, individual retirement 684
annuity, "Roth IRA," "529 plan," or education individual 685
retirement account that a decedent, upon or by reason of the 686
decedent's death, directly or indirectly left to or for the 687
benefit of the person, either outright or in trust or otherwise, 688
including, but not limited to, any of those rights or interests in 689
assets or to receive payments or benefits that were transferred, 690
conveyed, or otherwise transmitted by the decedent by means of a 691
will, trust, exercise of a power of appointment, beneficiary 692
designation, transfer or payment on death designation, or any 693
other method or procedure. 694

(f) The exemptions under divisions (A)(10)(a) to (e) of this 695
section also shall apply or otherwise be available to an alternate 696
payee under a qualified domestic relations order (QDRO) or other 697
similar court order. 698

(g) A person's interest in any plan, program, instrument, or 699
device described in divisions (A)(10)(a) to (e) of this section 700
shall be considered an exempt interest even if the plan, program, 701
instrument, or device in question, due to an error made in good 702
faith, failed to satisfy any criteria applicable to that plan, 703
program, instrument, or device under the "Internal Revenue Code of 704
1986," 100 Stat. 2085, 26 U.S.C. 1, as amended. 705

(11) The person's right to receive spousal support, child 706
support, an allowance, or other maintenance to the extent 707
reasonably necessary for the support of the person and any of the 708
person's dependents; 709

(12) The person's right to receive, or moneys received during 710
the preceding twelve calendar months from, any of the following: 711

(a) An award of reparations under sections 2743.51 to 2743.72 712

of the Revised Code, to the extent exempted by division (D) of 713
section 2743.66 of the Revised Code; 714

(b) A payment on account of the wrongful death of an 715
individual of whom the person was a dependent on the date of the 716
individual's death, to the extent reasonably necessary for the 717
support of the person and any of the person's dependents; 718

(c) Except in cases in which the person who receives the 719
payment is an inmate, as defined in section 2969.21 of the Revised 720
Code, and in which the payment resulted from a civil action or 721
appeal against a government entity or employee, as defined in 722
section 2969.21 of the Revised Code, a payment, not to exceed 723
twenty thousand two hundred dollars, on account of personal bodily 724
injury, not including pain and suffering or compensation for 725
actual pecuniary loss, of the person or an individual for whom the 726
person is a dependent; 727

(d) A payment in compensation for loss of future earnings of 728
the person or an individual of whom the person is or was a 729
dependent, to the extent reasonably necessary for the support of 730
the debtor and any of the debtor's dependents. 731

(13) Except as provided in sections 3119.80, 3119.81, 732
3121.02, 3121.03, and 3123.06 of the Revised Code, personal 733
earnings of the person owed to the person for services in an 734
amount equal to the greater of the following amounts: 735

(a) If paid weekly, thirty times the current federal minimum 736
hourly wage; if paid biweekly, sixty times the current federal 737
minimum hourly wage; if paid semimonthly, sixty-five times the 738
current federal minimum hourly wage; or if paid monthly, one 739
hundred thirty times the current federal minimum hourly wage that 740
is in effect at the time the earnings are payable, as prescribed 741
by the "Fair Labor Standards Act of 1938," 52 Stat. 1060, 29 742
U.S.C. 206(a)(1), as amended; 743

(b) Seventy-five per cent of the disposable earnings owed to the person.	744 745
(14) The person's right in specific partnership property, as exempted by the person's rights in a partnership pursuant to section 1776.50 of the Revised Code, except as otherwise set forth in section 1776.50 of the Revised Code;	746 747 748 749
(15) A seal and official register of a notary public, as exempted by section 147.04 of the Revised Code;	750 751
(16) The person's interest in a tuition unit or a payment under section 3334.09 of the Revised Code pursuant to a tuition payment contract, as exempted by section 3334.15 of the Revised Code;	752 753 754 755
(17) Any other property that is specifically exempted from execution, attachment, garnishment, or sale by federal statutes other than the "Bankruptcy Reform Act of 1978," 92 Stat. 2549, 11 U.S.C.A. 101, as amended;	756 757 758 759
(18) The person's aggregate interest in any property, not to exceed one thousand seventy-five dollars, except that division (A)(18) of this section applies only in bankruptcy proceedings.	760 761 762
(B) On April 1, 2010, and on the first day of April in each third calendar year after 2010, the Ohio judicial conference shall adjust each dollar amount set forth in this section to reflect any increase in the consumer price index for all urban consumers, as published by the United States department of labor, or, if that index is no longer published, a generally available comparable index, for the three-year period ending on the thirty-first day of December of the preceding year. Any adjustments required by this division shall be rounded to the nearest twenty-five dollars.	763 764 765 766 767 768 769 770 771
The Ohio judicial conference shall prepare a memorandum specifying the adjusted dollar amounts. The judicial conference shall transmit the memorandum to the director of the legislative	772 773 774

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

(C) As used in this section: 782

(1) "Disposable earnings" means net earnings after the 783
garnishee has made deductions required by law, excluding the 784
deductions ordered pursuant to section 3119.80, 3119.81, 3121.02, 785
3121.03, or 3123.06 of the Revised Code. 786

(2) "Insider" means: 787

(a) If the person who claims an exemption is an individual, a 788
relative of the individual, a relative of a general partner of the 789
individual, a partnership in which the individual is a general 790
partner, a general partner of the individual, or a corporation of 791
which the individual is a director, officer, or in control; 792

(b) If the person who claims an exemption is a corporation, a 793
director or officer of the corporation; a person in control of the 794
corporation; a partnership in which the corporation is a general 795
partner; a general partner of the corporation; or a relative of a 796
general partner, director, officer, or person in control of the 797
corporation; 798

(c) If the person who claims an exemption is a partnership, a 799
general partner in the partnership; a general partner of the 800
partnership; a person in control of the partnership; a partnership 801
in which the partnership is a general partner; or a relative in, a 802
general partner of, or a person in control of the partnership; 803

(d) An entity or person to which or whom any of the following 804
applies: 805

(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 148.01 of the Revised Code.

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

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

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

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

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

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

(1)(a) "Administrative expense" means the amount resulting from the following: the amount of premiums earned by the insurer for sickness and accident insurance business plus the amount of losses recovered from reinsurance coverage minus the sum of the amount of claims for losses paid; the amount of losses incurred but not reported; the amount incurred for state fees, federal and state taxes, and reinsurance; and the incurred costs and expenses related, either directly or indirectly, to the payment of commissions, measures to control fraud, and managed care.

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

(2) "Insurer" means any insurance company authorized under Title XXXIX of the Revised Code to do the business of sickness and

accident insurance in this state. 866

(3) "Sickness and accident insurance business" does not 867
include coverage provided by an insurer for specific diseases or 868
accidents only; any hospital indemnity, medicare supplement, 869
long-term care, disability income, one-time-limited-duration 870
policy ~~of no longer~~ that is less than six twelve months, or other 871
policy that offers only supplemental benefits; or coverage 872
provided to individuals who are not residents of this state. 873

(4) "Individual business" includes both individual sickness 874
and accident insurance and sickness and accident insurance made 875
available by insurers in the individual market to individuals, 876
with or without family members or dependents, through group 877
policies issued to one or more associations or entities. 878

(B) Notwithstanding section 3941.14 of the Revised Code, each 879
insurer shall have aggregate administrative expenses of no more 880
than twenty per cent of the premium income of the insurer, based 881
on the premiums earned in that year on the sickness and accident 882
insurance business of the insurer. 883

(C)(1) Each insurer, on the first day of January or within 884
sixty days thereafter, shall annually prepare, under oath, and 885
deposit in the office of the superintendent of insurance a 886
statement of the aggregate administrative expenses of the insurer, 887
based on the premiums earned in the immediately preceding calendar 888
year on the sickness and accident insurance business of the 889
insurer. The statement shall itemize and separately detail all of 890
the following information with respect to the insurer's sickness 891
and accident insurance business: 892

(a) The amount of premiums earned by the insurer both before 893
and after any costs related to the insurer's purchase of 894
reinsurance coverage; 895

(b) The total amount of claims for losses paid by the insurer 896

both before and after any reimbursement from reinsurance coverage;	897
(c) The amount of any losses incurred by the insurer but not reported by the insurer in the current or prior year;	898
(d) The amount of costs incurred by the insurer for state fees and federal and state taxes;	899
(e) The amount of costs incurred by the insurer for reinsurance coverage;	900
(f) The amount of costs incurred by the insurer for state fees and federal and state taxes;	901
(g) The amount of costs incurred by the insurer for reinsurance coverage;	902
(h) The amount of costs incurred by the insurer that are related to the insurer's payment of commissions;	903
(i) The amount of costs incurred by the insurer that are related to the insurer's fraud prevention measures;	904
(j) The amount of costs incurred by the insurer that are related to managed care; and	905
(k) Any other administrative expenses incurred by the insurer.	906
(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.	907
(D) No insurer shall fail to comply with this section.	908
(E) If the superintendent determines that an insurer has violated this section, the superintendent, pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, may order the suspension of the insurer's license to do the business of sickness and accident insurance in this state until the superintendent is satisfied that the insurer is in compliance with this section. If the insurer continues to do the business of sickness and accident insurance in this state while under the suspension order, the superintendent shall order the insurer to pay one thousand dollars for each day of the violation.	909
	910
	911
	912
	913
	914
	915
	916
	917
	918
	919
	920
	921
	922
	923
	924
	925
	926

(F) Any money collected by the superintendent under division 927
(E) of this section shall be deposited by the superintendent into 928
the state treasury to the credit of the department of insurance 929
operating fund. 930

(G) The statement of aggregate expenses filed pursuant to 931
this section separately detailing an insurer's individual, small 932
group, and large group business shall be considered work papers 933
resulting from the conduct of a market analysis of an entity 934
subject to examination by the superintendent under division (C) of 935
section 3901.48 of the Revised Code, except that the 936
superintendent may share aggregated market information that 937
identifies the premiums earned as reported under division 938
(C)(1)(a) of this section, the administrative expenses reported 939
under division (C)(1)(i) of this section, the amount of 940
commissions reported under division (C)(1)(f) of this section, the 941
amount of taxes paid as reported under division (C)(1)(d) of this 942
section, the total of the remaining benefit costs as reported 943
under divisions (C)(1)(b) and (c) of this section, and the amount 944
of fraud and managed care expenses reported under divisions 945
(C)(1)(g) and (h) of this section. 946

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the 947
Revised Code, every certificate furnished by an insurer in 948
connection with, or pursuant to any provision of, any group 949
sickness and accident insurance policy delivered, issued for 950
delivery, renewed, or used in this state on or after January 1, 951
1972, every policy of sickness and accident insurance delivered, 952
issued for delivery, renewed, or used in this state on or after 953
January 1, 1972, and every multiple employer welfare arrangement 954
offering an insurance program, which provides that coverage of an 955
unmarried dependent child of a parent or legal guardian will 956
terminate upon attainment of the limiting age for dependent 957
children specified in the contract shall also provide in substance 958

both of the following: 959

(1) Once an unmarried child has attained the limiting age for 960
dependent children, as provided in the policy, upon the request of 961
the insured, the insurer shall offer to cover the unmarried child 962
until the child attains ~~twenty-eight~~ twenty-six years of age if 963
all of the following are true: 964

(a) The child is the natural child, stepchild, or adopted 965
child of the insured. 966

(b) The child is a resident of this state or a full-time 967
student at an accredited public or private institution of higher 968
education. 969

(c) The child is not employed by an employer that offers any 970
health benefit plan under which the child is eligible for 971
coverage. 972

(d) The child is not eligible for the medicaid program or the 973
medicare program. 974

(2) That attainment of the limiting age for dependent 975
children shall not operate to terminate the coverage of a 976
dependent child if the child is and continues to be both of the 977
following: 978

(a) Incapable of self-sustaining employment by reason of 979
mental retardation or physical handicap; 980

(b) Primarily dependent upon the policyholder or certificate 981
holder for support and maintenance. 982

(B) Proof of such incapacity and dependence for purposes of 983
division (A)(2) of this section shall be furnished by the 984
policyholder or by the certificate holder to the insurer within 985
thirty-one days of the child's attainment of the limiting age. 986
Upon request, but not more frequently than annually after the 987
two-year period following the child's attainment of the limiting 988

age, the insurer may require proof satisfactory to it of the 989
continuance of such incapacity and dependency. 990

(C) Nothing in this section shall require an insurer to cover 991
a dependent child who is mentally retarded or physically 992
handicapped if the contract is underwritten on evidence of 993
insurability based on health factors set forth in the application, 994
or if such dependent child does not satisfy the conditions of the 995
contract as to any requirement for evidence of insurability or 996
other provision of the contract, satisfaction of which is required 997
for coverage thereunder to take effect. In any such case, the 998
terms of the contract shall apply with regard to the coverage or 999
exclusion of the dependent from such coverage. Nothing in this 1000
section shall apply to accidental death or dismemberment benefits 1001
provided by any such policy of sickness and accident insurance. 1002

(D) Nothing in this section shall do any of the following: 1003

(1) Require that any policy offer coverage for dependent 1004
children or provide coverage for an unmarried dependent child's 1005
children as dependents on the policy; 1006

(2) Require an employer to pay for any part of the premium 1007
for an unmarried dependent child that has attained the limiting 1008
age for dependents, as provided in the policy; 1009

(3) Require an employer to offer health insurance coverage to 1010
the dependents of any employee. 1011

(E) This section does not apply to any policies or 1012
certificates covering only accident, credit, dental, disability 1013
income, long-term care, hospital indemnity, medicare supplement, 1014
specified disease, or vision care; coverage under a 1015
one-time-limited-duration policy ~~of not longer~~ that is less than 1016
~~six~~ twelve months; coverage issued as a supplement to liability 1017
insurance; insurance arising out of a workers' compensation or 1018
similar law; automobile medical-payment insurance; or insurance 1019

under which benefits are payable with or without regard to fault 1020
and that is statutorily required to be contained in any liability 1021
insurance policy or equivalent self-insurance. 1022

(F) As used in this section, "health benefit plan" has the 1023
same meaning as in section 3924.01 of the Revised Code and also 1024
includes both of the following: 1025

(1) A public employee benefit plan; 1026

(2) A health benefit plan as regulated under the "Employee 1027
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 1028

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the 1029
Revised Code, any public employee benefit plan that provides that 1030
coverage of an unmarried dependent child will terminate upon 1031
attainment of the limiting age for dependent children specified in 1032
the plan shall also provide in substance both of the following: 1033

(1) Once an unmarried child has attained the limiting age for 1034
dependent children, as provided in the plan, upon the request of 1035
the employee, the public employee benefit plan shall offer to 1036
cover the unmarried child until the child attains ~~twenty-eight~~ 1037
twenty-six years of age if all of the following are true: 1038

(a) The child is the natural child, stepchild, or adopted 1039
child of the employee. 1040

(b) The child is a resident of this state or a full-time 1041
student at an accredited public or private institution of higher 1042
education. 1043

(c) The child is not employed by an employer that offers any 1044
health benefit plan under which the child is eligible for 1045
coverage. 1046

(d) The child is not eligible for the medicaid program or the 1047
medicare program. 1048

(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:	1049 1050 1051 1052
(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;	1053 1054
(b) Primarily dependent upon the plan member for support and maintenance.	1055 1056
(B) Proof of incapacity and dependence for purposes of division (A)(2) of this section shall be furnished to the public employee benefit plan within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the public employee benefit plan may require proof satisfactory to it of the continuance of such incapacity and dependency.	1057 1058 1059 1060 1061 1062 1063
(C) Nothing in this section shall do any of the following:	1064
(1) Require that any public employee benefit plan offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the public employee benefit plan;	1065 1066 1067 1068
(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;	1069 1070 1071
(3) Require an employer to offer health insurance coverage to the dependents of any employee.	1072 1073
(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 <u>that is less</u> than	1074 1075 1076 1077 1078

~~six~~ twelve 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.

(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:

(1) A public employee benefit plan;

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

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

(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 psychiatric association.

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

(B) Notwithstanding section 3901.71 of the Revised Code, and 1109
subject to division (E) of this section, every policy of sickness 1110
and accident insurance shall provide benefits for the diagnosis 1111
and treatment of biologically based mental illnesses on the same 1112
terms and conditions as, and shall provide benefits no less 1113
extensive than, those provided under the policy of sickness and 1114
accident insurance for the treatment and diagnosis of all other 1115
physical diseases and disorders, if both of the following apply: 1116

(1) The biologically based mental illness is clinically 1117
diagnosed by a physician authorized under Chapter 4731. of the 1118
Revised Code to practice medicine and surgery or osteopathic 1119
medicine and surgery; a psychologist licensed under Chapter 4732. 1120
of the Revised Code; a licensed professional clinical counselor, 1121
licensed professional counselor, independent social worker, or 1122
independent marriage and family therapist licensed under Chapter 1123
4757. of the Revised Code; or a clinical nurse specialist or 1124
certified nurse practitioner licensed under Chapter 4723. of the 1125
Revised Code whose nursing specialty is mental health. 1126

(2) The prescribed treatment is not experimental or 1127
investigational, having proven its clinical effectiveness in 1128
accordance with generally accepted medical standards. 1129

(C) Division (B) of this section applies to all coverages and 1130
terms and conditions of the policy of sickness and accident 1131
insurance, including, but not limited to, coverage of inpatient 1132
hospital services, outpatient services, and medication; maximum 1133
lifetime benefits; copayments; and individual and family 1134
deductibles. 1135

(D) Nothing in this section shall be construed as prohibiting 1136
a sickness and accident insurance company from taking any of the 1137
following actions: 1138

(1) Negotiating separately with mental health care providers 1139

with regard to reimbursement rates and the delivery of health care services;	1140 1141
(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses;	1142 1143
(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;	1144 1145 1146 1147 1148 1149
(4) Enforcing the terms and conditions of a policy of sickness and accident insurance.	1150 1151
(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:	1152 1153 1154 1155 1156
(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 the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.	1157 1158 1159 1160 1161 1162 1163 1164
(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and	1165 1166 1167 1168 1169 1170

disorders. 1171

(3) The superintendent of insurance makes the following 1172
determinations from the documentation and opinion submitted 1173
pursuant to divisions (E)(1) and (2) of this section: 1174

(a) Incurred claims for diagnostic and treatment services for 1175
biologically based mental illnesses for a period of at least six 1176
months independently caused the insurer's costs for claims and 1177
administrative expenses for the coverage of all other physical 1178
diseases and disorders to increase by more than one per cent per 1179
year. 1180

(b) The increase in costs reasonably justifies an increase of 1181
more than one per cent in the annual premiums or rates charged by 1182
the insurer for the coverage of all other physical diseases and 1183
disorders. 1184

Any determination made by the superintendent under this 1185
division is subject to Chapter 119. of the Revised Code. 1186

Sec. 3923.57. Notwithstanding any provision of this chapter, 1187
every individual policy of sickness and accident insurance that is 1188
delivered, issued for delivery, or renewed in this state is 1189
subject to the following conditions, as applicable: 1190

(A) Pre-existing conditions provisions shall not exclude or 1191
limit coverage for a period beyond twelve months following the 1192
policyholder's effective date of coverage and may only relate to 1193
conditions during the six months immediately preceding the 1194
effective date of coverage. 1195

(B) In determining whether a pre-existing conditions 1196
provision applies to a policyholder or dependent, each policy 1197
shall credit the time the policyholder or dependent was covered 1198
under a previous policy, contract, or plan if the previous 1199
coverage was continuous to a date not more than thirty days prior 1200

to the effective date of the new coverage, exclusive of any 1201
applicable service waiting period under the policy. 1202

(C)(1) Except as otherwise provided in division (C) of this 1203
section, an insurer that provides an individual sickness and 1204
accident insurance policy to an individual shall renew or continue 1205
in force such coverage at the option of the individual. 1206

(2) An insurer may nonrenew or discontinue coverage of an 1207
individual in the individual market based only on one or more of 1208
the following reasons: 1209

(a) The individual failed to pay premiums or contributions in 1210
accordance with the terms of the policy or the insurer has not 1211
received timely premium payments. 1212

(b) The individual performed an act or practice that 1213
constitutes fraud or made an intentional misrepresentation of 1214
material fact under the terms of the policy. 1215

(c) The insurer is ceasing to offer coverage in the 1216
individual market in accordance with division (D) of this section 1217
and the applicable laws of this state. 1218

(d) If the insurer offers coverage in the market through a 1219
network plan, the individual no longer resides, lives, or works in 1220
the service area, or in an area for which the insurer is 1221
authorized to do business; provided, however, that such coverage 1222
is terminated uniformly without regard to any health 1223
status-related factor of covered individuals. 1224

(e) If the coverage is made available in the individual 1225
market only through one or more bona fide associations, the 1226
membership of the individual in the association, on the basis of 1227
which the coverage is provided, ceases; provided, however, that 1228
such coverage is terminated under division (C)(2)(e) of this 1229
section uniformly without regard to any health status-related 1230
factor of covered individuals. 1231

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of 1294
this section also apply to all group sickness and accident 1295
insurance policies that are not sold in connection with an 1296
employment-related group health plan and that provide more than 1297
short-term, limited duration coverage. 1298

In applying divisions (C) to (G) of this section with respect 1299
to health insurance coverage that is made available by an insurer 1300
in the individual market to individuals only through one or more 1301
associations, the term "individual" includes the association of 1302
which the individual is a member. 1303

For purposes of this section, any policy issued pursuant to 1304
division (C) of section 3923.13 of the Revised Code in connection 1305
with a public or private college or university student health 1306
insurance program is considered to be issued to a bona fide 1307
association. 1308

As used in this section, "bona fide association" has the same 1309
meaning as in section 3924.03 of the Revised Code, and "health 1310
status-related factor" and "network plan" have the same meanings 1311
as in section 3924.031 of the Revised Code. 1312

This section does not apply to any policy that provides 1313
coverage for specific diseases or accidents only, or to any 1314
hospital indemnity, medicare supplement, long-term care, 1315
disability income, one-time-limited-duration policy ~~of no longer~~ 1316
that is less than six twelve months, or other policy that offers 1317
only supplemental benefits. 1318

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 1319
the Revised Code: 1320

(1) "Base rate" means, as to any health benefit plan that is 1321
issued by a carrier in the individual market, the lowest premium 1322
rate for new or existing business prescribed by the carrier for 1323

the same or similar coverage under a plan or arrangement covering 1324
any individual with similar case characteristics. 1325

(2) "Carrier," "health benefit plan," and "MEWA" have the 1326
same meanings as in section 3924.01 of the Revised Code. 1327

(3) "Network plan" means a health benefit plan of a carrier 1328
under which the financing and delivery of medical care, including 1329
items and services paid for as medical care, are provided, in 1330
whole or in part, through a defined set of providers under 1331
contract with the carrier. 1332

(4) "Ohio health care basic and standard plans" means those 1333
plans established under section 3924.10 of the Revised Code. 1334

(5) "Pre-existing conditions provision" means a policy 1335
provision that excludes or limits coverage for charges or expenses 1336
incurred during a specified period following the insured's 1337
effective date of coverage as to a condition which, during a 1338
specified period immediately preceding the effective date of 1339
coverage, had manifested itself in such a manner as would cause an 1340
ordinarily prudent person to seek medical advice, diagnosis, care, 1341
or treatment or for which medical advice, diagnosis, care, or 1342
treatment was recommended or received, or a pregnancy existing on 1343
the effective date of coverage. 1344

(B) Beginning in January of each year, carriers in the 1345
business of issuing health benefit plans to individuals and 1346
nonemployer groups, except individual health benefit plans issued 1347
pursuant to sections 1751.16 and 3923.122 of the Revised Code, 1348
shall accept applicants for open enrollment coverage, as set forth 1349
in this division, in the order in which they apply for coverage 1350
and subject to the limitation set forth in division (G) of this 1351
section. Carriers shall accept for coverage pursuant to this 1352
section individuals to whom both of the following conditions 1353
apply: 1354

(1) The individual is not applying for coverage as an 1355
employee of an employer, as a member of an association, or as a 1356
member of any other group. 1357

(2) The individual is not covered, and is not eligible for 1358
coverage, under any other private or public health benefits 1359
arrangement, including the medicare program established under 1360
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 1361
U.S.C.A. 301, as amended, or any other act of congress or law of 1362
this or any other state of the United States that provides 1363
benefits comparable to the benefits provided under this section, 1364
any medicare supplement policy, or any continuation of coverage 1365
policy under state or federal law. 1366

(C) A carrier shall offer to any individual accepted under 1367
this section the Ohio health care basic and standard plans or 1368
health benefit plans that are substantially similar to the Ohio 1369
health care basic and standard plans in benefit plan design and 1370
scope of covered services. 1371

A carrier may offer other health benefit plans in addition 1372
to, but not in lieu of, the plans required to be offered under 1373
this division. A basic health benefit plan shall provide, at a 1374
minimum, the coverage provided by the Ohio health care basic plan 1375
or any health benefit plan that is substantially similar to the 1376
Ohio health care basic plan in benefit plan design and scope of 1377
covered services. A standard health benefit plan shall provide, at 1378
a minimum, the coverage provided by the Ohio health care standard 1379
plan or any health benefit plan that is substantially similar to 1380
the Ohio health care standard plan in benefit plan design and 1381
scope of covered services. 1382

For purposes of this division, the superintendent of 1383
insurance shall determine whether a health benefit plan is 1384
substantially similar to the Ohio health care basic and standard 1385
plans in benefit plan design and scope of covered services. 1386

(D)(1) Health benefit plans issued under this section may 1387
establish pre-existing conditions provisions that exclude or limit 1388
coverage for a period of up to twelve months following the 1389
individual's effective date of coverage and that may relate only 1390
to conditions during the six months immediately preceding the 1391
effective date of coverage. A health insuring corporation may 1392
apply a pre-existing condition provision for any basic health care 1393
service related to a transplant of a body organ if the transplant 1394
occurs within one year after the effective date of an enrollee's 1395
coverage under this section except with respect to a newly born 1396
child who meets the requirements for coverage under section 1397
1751.61 of the Revised Code. 1398

(2) In determining whether a pre-existing conditions 1399
provision applies to an insured or dependent, each policy shall 1400
credit the time the insured or dependent was covered under a 1401
previous policy, contract, or plan if the previous coverage was 1402
continuous to a date not more than sixty-three days prior to the 1403
effective date of the new coverage, exclusive of any applicable 1404
service waiting period under the policy. 1405

(E) Premiums charged to individuals under this section may 1406
not exceed the amounts specified below: 1407

(1) For calendar years 2010 and 2011, an amount that is two 1408
times the base rate for coverage offered to any other individual 1409
to which the carrier is currently accepting new business, and for 1410
which similar copayments and deductibles are applied; 1411

(2) For calendar year 2012 and every year thereafter, an 1412
amount that is one and one-half times the base rate for coverage 1413
offered to any other individual to which the carrier is currently 1414
accepting new business and for which similar copayments and 1415
deductibles are applied, unless the superintendent of insurance 1416
determines that the amendments by this act to this section and 1417
section 3923.581 of the Revised Code, have resulted in the 1418

market-wide average medical loss ratio for coverage sold to 1419
individual insureds and nonemployer group insureds in this state, 1420
including open enrollment insureds, to increase by more than five 1421
and one quarter percentage points during calendar year 2010. If 1422
the superintendent makes that determination, the premium limit 1423
established by division (E)(1) of this section shall remain in 1424
effect. The superintendent's determination shall be supported by a 1425
signed letter from a member of the American academy of actuaries. 1426

(F) In offering health benefit plans under this section, a 1427
carrier may require the purchase of health benefit plans that 1428
condition the reimbursement of health services upon the use of a 1429
specific network of providers. 1430

(G)(1) A carrier shall not be required to accept new 1431
applicants under this section if the total number of the carrier's 1432
current insureds with open enrollment coverage issued under this 1433
section calculated as of the immediately preceding thirty-first 1434
day of December and excluding the carrier's medicare supplement 1435
policies and conversion or continuation of coverage policies under 1436
state or federal law and any policies described in division (L) of 1437
this section meets the following limits: 1438

(a) For calendar years 2010 and 2011, four per cent of the 1439
carrier's total number of individual or nonemployer group insureds 1440
in this state; 1441

(b) For calendar year 2012 and every year thereafter, eight 1442
per cent of the carrier's total number of insured individuals and 1443
nonemployer group insureds in this state, unless the 1444
superintendent of insurance determines that the amendments by this 1445
act to this section and section 3923.581 of the Revised Code, have 1446
resulted in the market-wide average medical loss ratio for 1447
coverage sold to individual insureds and nonemployer group 1448
insureds in this state, including open enrollment insureds, to 1449
increase by more than five and one quarter percentage points 1450

during calendar year 2010. If the superintendent makes that 1451
determination, the enrollment limit established by division 1452
(G)(1)(a) of this section shall remain in effect. The 1453
superintendent's determination shall be supported by a signed 1454
letter from a member of the American academy of actuaries. 1455

(2) An officer of the carrier shall certify to the department 1456
of insurance when it has met the enrollment limit set forth in 1457
division (G)(1) of this section. Upon providing such 1458
certification, the carrier shall be relieved of its open 1459
enrollment requirement under this section as long as the carrier 1460
continues to meet the open enrollment limit. If the total number 1461
of the carrier's current insureds with open enrollment coverage 1462
issued under this section falls below the enrollment limit, the 1463
carrier shall accept new applicants. A carrier may establish a 1464
waiting list if the carrier has met the open enrollment limit and 1465
shall notify the superintendent if the carrier has a waiting list 1466
in effect. 1467

(H) A carrier shall not be required to accept under this 1468
section applicants who, at the time of enrollment, are confined to 1469
a health care facility because of chronic illness, permanent 1470
injury, or other infirmity that would cause economic impairment to 1471
the carrier if the applicants were accepted. A carrier shall not 1472
be required to make the effective date of benefits for individuals 1473
accepted under this section earlier than ninety days after the 1474
date of acceptance, except that when the individual had prior 1475
coverage with a health benefit plan that was terminated by a 1476
carrier because the carrier exited the market and the individual 1477
was accepted for open enrollment under this section within 1478
sixty-three days of that termination, the effective date of 1479
benefits shall be the date of enrollment. 1480

(I) The requirements of this section do not apply to any 1481
carrier that is currently in a state of supervision, insolvency, 1482

or liquidation. If a carrier demonstrates to the satisfaction of 1483
the superintendent that the requirements of this section would 1484
place the carrier in a state of supervision, insolvency, or 1485
liquidation, or would otherwise jeopardize the carrier's economic 1486
viability overall or in the individual market, the superintendent 1487
may waive or modify the requirements of division (B) or (G) of 1488
this section. The actions of the superintendent under this 1489
division shall be effective for a period of not more than one 1490
year. At the expiration of such time, a new showing of need for a 1491
waiver or modification by the carrier shall be made before a new 1492
waiver or modification is issued or imposed. 1493

(J) No hospital, health care facility, or health care 1494
practitioner, and no person who employs any health care 1495
practitioner, shall balance bill any individual or dependent of an 1496
individual for any health care supplies or services provided to 1497
the individual or dependent who is insured under a policy issued 1498
under this section. The hospital, health care facility, or health 1499
care practitioner, or any person that employs the health care 1500
practitioner, shall accept payments made to it by the carrier 1501
under the terms of the policy or contract insuring or covering 1502
such individual as payment in full for such health care supplies 1503
or services. 1504

As used in this division, "hospital" has the same meaning as 1505
in section 3727.01 of the Revised Code; "health care practitioner" 1506
has the same meaning as in section 4769.01 of the Revised Code; 1507
and "balance bill" means charging or collecting an amount in 1508
excess of the amount reimbursable or payable under the policy or 1509
health care service contract issued to an individual under this 1510
section for such health care supply or service. "Balance bill" 1511
does not include charging for or collecting copayments or 1512
deductibles required by the policy or contract. 1513

(K) A carrier may pay an agent a commission in the amount of 1514

not more than five per cent of the premium charged for initial 1515
placement or for otherwise securing the issuance of a policy or 1516
contract issued to an individual under this section, and not more 1517
than four per cent of the premium charged for the renewal of such 1518
a policy or contract. The superintendent may adopt, in accordance 1519
with Chapter 119. of the Revised Code, such rules as are necessary 1520
to enforce this division. 1521

(L) This section does not apply to any policy that provides 1522
coverage for specific diseases or accidents only, or to any 1523
hospital indemnity, medicare supplement, long-term care, 1524
disability income, one-time-limited-duration policy ~~of no longer~~ 1525
that is less than ~~six~~ twelve months, or other policy that offers 1526
only supplemental benefits. 1527

(M) If a carrier offers a health benefit plan in the 1528
individual market through a network plan, the carrier may do both 1529
of the following: 1530

(1) Limit the individuals that may apply for such coverage to 1531
those who live, work, or reside in the service area of the network 1532
plan; 1533

(2) Within the service area of the network plan, deny the 1534
coverage to individuals if the carrier has demonstrated both of 1535
the following to the superintendent: 1536

(a) The carrier will not have the capacity to deliver 1537
services adequately to any additional individuals because of the 1538
carrier's obligations to existing group contract holders and 1539
individuals. 1540

(b) The carrier is applying division (M)(2) of this section 1541
uniformly to all individuals without regard to any health 1542
status-related factors of those individuals. 1543

(N) A carrier that, pursuant to division (M)(2) of this 1544
section, denies coverage to an individual in the service area of a 1545

network plan, shall not offer coverage in the individual market 1546
within that service area for at least one hundred eighty days 1547
after the date the carrier denies the coverage. 1548

Sec. 3923.601. (A)(1) This section applies to both of the 1549
following: 1550

(a) A sickness and accident insurer that issues or requires 1551
the use of a standardized identification card or an electronic 1552
technology for submission and routing of prescription drug claims 1553
pursuant to a policy, contract, or agreement for health care 1554
services; 1555

(b) A person that a sickness and accident insurer contracts 1556
with to issue a standardized identification card or an electronic 1557
technology described in division (A)(1)(a) of this section. 1558

(2) Notwithstanding division (A)(1) of this section, this 1559
section does not apply to the issuance or required use of a 1560
standardized identification card or an electronic technology for 1561
the submission and routing of prescription drug claims in 1562
connection with any of the following: 1563

(a) Any individual or group policy of sickness and accident 1564
insurance covering only accident, credit, dental, disability 1565
income, long-term care, hospital indemnity, medicare supplement, 1566
medicare, tricare, specified disease, or vision care; coverage 1567
under a one-time-limited-duration policy ~~of not longer than~~ that is 1568
less than ~~six~~ twelve months; coverage issued as a supplement to 1569
liability insurance; insurance arising out of workers' 1570
compensation or similar law; automobile medical payment insurance; 1571
or insurance under which benefits are payable with or without 1572
regard to fault and which is statutorily required to be contained 1573
in any liability insurance policy or equivalent self-insurance. 1574

(b) Coverage provided under the medicaid program. 1575

(c) Coverage provided under an employer's self-insurance plan 1576
or by any of its administrators, as defined in section 3959.01 of 1577
the Revised Code, to the extent that federal law supersedes, 1578
preempts, prohibits, or otherwise precludes the application of 1579
this section to the plan and its administrators. 1580

(B) A standardized identification card or an electronic 1581
technology issued or required to be used as provided in division 1582
(A)(1) of this section shall contain uniform prescription drug 1583
information in accordance with either division (B)(1) or (2) of 1584
this section. 1585

(1) The standardized identification card or the electronic 1586
technology shall be in a format and contain information fields 1587
approved by the national council for prescription drug programs or 1588
a successor organization, as specified in the council's or 1589
successor organization's pharmacy identification card 1590
implementation guide in effect on the first day of October most 1591
immediately preceding the issuance or required use of the 1592
standardized identification card or the electronic technology. 1593

(2) If the insurer or person under contract with the insurer 1594
to issue a standardized identification card or an electronic 1595
technology requires the information for the submission and routing 1596
of a claim, the standardized identification card or the electronic 1597
technology shall contain any of the following information: 1598

(a) The insurer's name; 1599

(b) The insured's name, group number, and identification 1600
number; 1601

(c) A telephone number to inquire about pharmacy-related 1602
issues; 1603

(d) The issuer's international identification number, labeled 1604
as "ANSI BIN" or "RxBIN"; 1605

(e) The processor's control number, labeled as "RxPCN"; 1606

(f) The insured's pharmacy benefits group number if different 1607
from the insured's medical group number, labeled as "RxGrp." 1608

(C) If the standardized identification card or the electronic 1609
technology issued or required to be used as provided in division 1610
(A)(1) of this section is also used for submission and routing of 1611
nonpharmacy claims, the designation "Rx" is required to be 1612
included as part of the labels identified in divisions (B)(2)(d) 1613
and (e) of this section if the issuer's international 1614
identification number or the processor's control number is 1615
different for medical and pharmacy claims. 1616

(D) Each sickness and accident insurer described in division 1617
(A) of this section shall annually file a certificate with the 1618
superintendent of insurance certifying that it or any person it 1619
contracts with to issue a standardized identification card or 1620
electronic technology for submission and routing of prescription 1621
drug claims complies with this section. 1622

(E)(1) Except as provided in division (E)(2) of this section, 1623
if there is a change in the information contained in the 1624
standardized identification card or the electronic technology 1625
issued to an insured, the insurer or person under contract with 1626
the insurer to issue a standardized identification card or an 1627
electronic technology shall issue a new card or electronic 1628
technology to the insured. 1629

(2) An insurer or person under contract with the insurer is 1630
not required under division (E)(1) of this section to issue a new 1631
card or electronic technology to an insured more than once during 1632
a twelve-month period. 1633

(F) Nothing in this section shall be construed as requiring 1634
an insurer to produce more than one standardized identification 1635
card or one electronic technology for use by insureds accessing 1636

health care benefits provided under a policy of sickness and 1637
accident insurance. 1638

Sec. 3923.65. (A) As used in this section: 1639

(1) "Emergency medical condition" means a medical condition 1640
that manifests itself by such acute symptoms of sufficient 1641
severity, including severe pain, that a prudent layperson with 1642
average knowledge of health and medicine could reasonably expect 1643
the absence of immediate medical attention to result in any of the 1644
following: 1645

(a) Placing the health of the individual or, with respect to 1646
a pregnant woman, the health of the woman or her unborn child, in 1647
serious jeopardy; 1648

(b) Serious impairment to bodily functions; 1649

(c) Serious dysfunction of any bodily organ or part. 1650

(2) "Emergency services" means the following: 1651

(a) A medical screening examination, as required by federal 1652
law, that is within the capability of the emergency department of 1653
a hospital, including ancillary services routinely available to 1654
the emergency department, to evaluate an emergency medical 1655
condition; 1656

(b) Such further medical examination and treatment that are 1657
required by federal law to stabilize an emergency medical 1658
condition and are within the capabilities of the staff and 1659
facilities available at the hospital, including any trauma and 1660
burn center of the hospital. 1661

(B) Every individual or group policy of sickness and accident 1662
insurance that provides hospital, surgical, or medical expense 1663
coverage shall cover emergency services without regard to the day 1664
or time the emergency services are rendered or to whether the 1665
policyholder, the hospital's emergency department where the 1666

services are rendered, or an emergency physician treating the 1667
policyholder, obtained prior authorization for the emergency 1668
services. 1669

(C) Every individual policy or certificate furnished by an 1670
insurer in connection with any sickness and accident insurance 1671
policy shall provide information regarding the following: 1672

(1) The scope of coverage for emergency services; 1673

(2) The appropriate use of emergency services, including the 1674
use of the 9-1-1 system and any other telephone access systems 1675
utilized to access prehospital emergency services; 1676

(3) Any copayments for emergency services. 1677

(D) This section does not apply to any individual or group 1678
policy of sickness and accident insurance covering only accident, 1679
credit, dental, disability income, long-term care, hospital 1680
indemnity, medicare supplement, medicare, tricare, specified 1681
disease, or vision care; coverage under a one-time limited 1682
duration policy ~~of no longer~~ that is less than six ~~twelve~~ months; 1683
coverage issued as a supplement to liability insurance; insurance 1684
arising out of workers' compensation or similar law; automobile 1685
medical payment insurance; or insurance under which benefits are 1686
payable with or without regard to fault and which is statutorily 1687
required to be contained in any liability insurance policy or 1688
equivalent self-insurance. 1689

Sec. 3923.83. (A)(1) This section applies to both of the 1690
following: 1691

(a) A public employee benefit plan that issues or requires 1692
the use of a standardized identification card or an electronic 1693
technology for submission and routing of prescription drug claims 1694
pursuant to a policy, contract, or agreement for health care 1695
services; 1696

(b) A person or entity that a public employee benefit plan contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section. 1697
1698
1699
1700

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with either of the following: 1701
1702
1703
1704
1705

(a) Any individual or group policy of insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer than~~ that is less than ~~six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 1706
1707
1708
1709
1710
1711
1712
1713
1714
1715
1716

(b) Coverage provided under the medicaid program. 1717

(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. 1718
1719
1720
1721
1722

(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 1723
1724
1725
1726
1727

implementation guide in effect on the first day of October most 1728
immediately preceding the issuance or required use of the 1729
standardized identification card or the electronic technology. 1730

(2) If the public employee benefit plan or person under 1731
contract with the plan to issue a standardized identification card 1732
or an electronic technology requires the information for the 1733
submission and routing of a claim, the standardized identification 1734
card or the electronic technology shall contain any of the 1735
following information: 1736

(a) The plan's name; 1737

(b) The insured's name, group number, and identification 1738
number; 1739

(c) A telephone number to inquire about pharmacy-related 1740
issues; 1741

(d) The issuer's international identification number, labeled 1742
as "ANSI BIN" or "RxBIN"; 1743

(e) The processor's control number, labeled as "RxPCN"; 1744

(f) The insured's pharmacy benefits group number if different 1745
from the insured's medical group number, labeled as "RxGrp." 1746

(C) If the standardized identification card or the electronic 1747
technology issued or required to be used as provided in division 1748
(A)(1) of this section is also used for submission and routing of 1749
nonpharmacy claims, the designation "Rx" is required to be 1750
included as part of the labels identified in divisions (B)(2)(d) 1751
and (e) of this section if the issuer's international 1752
identification number or the processor's control number is 1753
different for medical and pharmacy claims. 1754

(D)(1) Except as provided in division (D)(2) of this section, 1755
if there is a change in the information contained in the 1756
standardized identification card or the electronic technology 1757

issued to an insured, the public employee benefit plan or person 1758
under contract with the plan to issue a standardized 1759
identification card or electronic technology shall issue a new 1760
card or electronic technology to the insured. 1761

(2) A public employee benefit plan or person under contract 1762
with the plan is not required under division (D)(1) of this 1763
section to issue a new card or electronic technology to an insured 1764
more than once during a twelve-month period. 1765

(E) Nothing in this section shall be construed as requiring a 1766
public employee benefit plan to produce more than one standardized 1767
identification card or one electronic technology for use by 1768
insureds accessing health care benefits provided under a health 1769
benefit plan. 1770

Sec. 3923.85. (A) As used in this section, "cost sharing" 1771
means the cost to an individual insured under an individual or 1772
group policy of sickness and accident insurance or a public 1773
employee benefit plan according to any coverage limit, copayment, 1774
coinsurance, deductible, or other out-of-pocket expense 1775
requirements imposed by the policy or plan. 1776

(B) Notwithstanding section 3901.71 of the Revised Code and 1777
subject to division (D) of this section, no individual or group 1778
policy of sickness and accident insurance that is delivered, 1779
issued for delivery, or renewed in this state and no public 1780
employee benefit plan that is established or modified in this 1781
state shall fail to comply with either of the following: 1782

(1) The policy or plan shall not provide coverage or impose 1783
cost sharing for a prescribed, orally administered cancer 1784
medication on a less favorable basis than the coverage it provides 1785
or cost sharing it imposes for intravenously administered or 1786
injected cancer medications. 1787

(2) The policy or plan shall not comply with division (B)(1) 1788
of this section by imposing an increase in cost sharing solely for 1789
orally administered, intravenously administered, or injected 1790
cancer medications. 1791

(C) Notwithstanding any provision of this section to the 1792
contrary, a policy or plan shall be deemed to be in compliance 1793
with this section if the cost sharing imposed under such a policy 1794
or plan for orally administered cancer treatments does not exceed 1795
one hundred dollars per prescription fill. The cost sharing limit 1796
of one hundred dollars per prescription fill shall apply to a high 1797
deductible plan, as defined in 26 U.S.C. 223, or a catastrophic 1798
plan, as defined in 42 U.S.C. 18022, only after the deductible has 1799
been met. 1800

(D)(1) The prohibitions in division (B) of this section do 1801
not preclude an individual or group policy of sickness and 1802
accident insurance or public employee benefit plan from requiring 1803
an insured or plan member to obtain prior authorization before 1804
orally administered cancer medication is dispensed to the insured 1805
or plan member. 1806

(2) Division (B) of this section does not apply to the offer 1807
or renewal of any individual or group policy of sickness and 1808
accident insurance that provides coverage for specific diseases or 1809
accidents only, or to any hospital indemnity, medicare supplement, 1810
disability income, or other policy that offers only supplemental 1811
benefits. 1812

(E) An insurer that offers any sickness and accident 1813
insurance or any public employee benefit plan that offers coverage 1814
for basic health care services is not required to comply with 1815
division (B) of this section if all of the following apply: 1816

(1) The insurer or plan submits documentation certified by an 1817
independent member of the American academy of actuaries to the 1818

superintendent of insurance showing that compliance with division 1819
(B)(1) of this section for a period of at least six months 1820
independently caused the insurer or plan's costs for claims and 1821
administrative expenses for the coverage of basic health care 1822
services to increase by more than one per cent per year. 1823

(2) The insurer or plan submits a signed letter from an 1824
independent member of the American academy of actuaries to the 1825
superintendent of insurance opining that the increase in costs 1826
described in division (E)(1) of this section could reasonably 1827
justify an increase of more than one per cent in the annual 1828
premiums or rates charged by the insurer or plan for the coverage 1829
of basic health care services. 1830

(3)(a) The superintendent of insurance makes the following 1831
determinations from the documentation and opinion submitted 1832
pursuant to divisions (E)(1) and (2) of this section: 1833

(i) Compliance with division (B)(1) of this section for a 1834
period of at least six months independently caused the insurer or 1835
plan's costs for claims and administrative expenses for the 1836
coverage of basic health care services to increase more than one 1837
per cent per year. 1838

(ii) The increase in costs reasonably justifies an increase 1839
of more than one per cent in the annual premiums or rates charged 1840
by the insurer or plan for the coverage of basic health care 1841
services. 1842

(b) Any determination made by the superintendent under 1843
division (E)(3) of this section is subject to Chapter 119. of the 1844
Revised Code. 1845

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the 1846
Revised Code: 1847

(A) "Actuarial certification" means a written statement 1848

prepared by a member of the American academy of actuaries, or by 1849
any other person acceptable to the superintendent of insurance, 1850
that states that, based upon the person's examination, a carrier 1851
offering health benefit plans to small employers is in compliance 1852
with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial 1853
certification" shall include a review of the appropriate records 1854
of, and the actuarial assumptions and methods used by, the carrier 1855
relative to establishing premium rates for the health benefit 1856
plans. 1857

(B) "Adjusted average market premium price" means the average 1858
market premium price as determined by the board of directors of 1859
the Ohio health reinsurance program either on the basis of the 1860
arithmetic mean of all carriers' premium rates for an OHC plan 1861
sold to groups with similar case characteristics by all carriers 1862
selling OHC plans in the state, or on any other equitable basis 1863
determined by the board. 1864

(C) "Base premium rate" means, as to any health benefit plan 1865
that is issued by a carrier and that covers at least two but no 1866
more than fifty employees of a small employer, the lowest premium 1867
rate for a new or existing business prescribed by the carrier for 1868
the same or similar coverage under a plan or arrangement covering 1869
any small employer with similar case characteristics. 1870

(D) "Carrier" means any sickness and accident insurance 1871
company or health insuring corporation authorized to issue health 1872
benefit plans in this state or a MEWA. A sickness and accident 1873
insurance company that owns or operates a health insuring 1874
corporation, either as a separate corporation or as a line of 1875
business, shall be considered as a separate carrier from that 1876
health insuring corporation for purposes of sections 3924.01 to 1877
3924.14 of the Revised Code. 1878

(E) "Case characteristics" means, with respect to a small 1879
employer, the geographic area in which the employees work; the age 1880

and sex of the individual employees and their dependents; the 1881
appropriate industry classification as determined by the carrier; 1882
the number of employees and dependents; and such other objective 1883
criteria as may be established by the carrier. "Case 1884
characteristics" does not include claims experience, health 1885
status, or duration of coverage from the date of issue. 1886

(F) "Dependent" means the spouse or child of an eligible 1887
employee, subject to applicable terms of the health benefits plan 1888
covering the employee. 1889

(G) "Eligible employee" means an employee who works a normal 1890
work week of ~~twenty-five~~ thirty or more hours. "Eligible employee" 1891
does not include a temporary or substitute employee, or a seasonal 1892
employee who works only part of the calendar year on the basis of 1893
natural or suitable times or circumstances. 1894

(H) "Health benefit plan" means any hospital or medical 1895
expense policy or certificate or any health plan provided by a 1896
carrier, that is delivered, issued for delivery, renewed, or used 1897
in this state on or after the date occurring six months after 1898
November 24, 1995. "Health benefit plan" does not include policies 1899
covering only accident, credit, dental, disability income, 1900
long-term care, hospital indemnity, medicare supplement, specified 1901
disease, or vision care; coverage under a 1902
one-time-limited-duration policy ~~of no longer~~ that is less than 1903
~~six~~ twelve months; coverage issued as a supplement to liability 1904
insurance; insurance arising out of a workers' compensation or 1905
similar law; automobile medical-payment insurance; or insurance 1906
under which benefits are payable with or without regard to fault 1907
and which is statutorily required to be contained in any liability 1908
insurance policy or equivalent self-insurance. 1909

(I) "Late enrollee" means an eligible employee or dependent 1910
who enrolls in a small employer's health benefit plan other than 1911
during the first period in which the employee or dependent is 1912

eligible to enroll under the plan or during a special enrollment 1913
period described in section 2701(f) of the "Health Insurance 1914
Portability and Accountability Act of 1996," Pub. L. No. 104-191, 1915
110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 1916

(J) "MEWA" means any "multiple employer welfare arrangement" 1917
as defined in section 3 of the "Federal Employee Retirement Income 1918
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 1919
except for any arrangement which is fully insured as defined in 1920
division (b)(6)(D) of section 514 of that act. 1921

(K) "Midpoint rate" means, for small employers with similar 1922
case characteristics and plan designs and as determined by the 1923
applicable carrier for a rating period, the arithmetic average of 1924
the applicable base premium rate and the corresponding highest 1925
premium rate. 1926

(L) "Pre-existing conditions provision" means a policy 1927
provision that excludes or limits coverage for charges or expenses 1928
incurred during a specified period following the insured's 1929
enrollment date as to a condition for which medical advice, 1930
diagnosis, care, or treatment was recommended or received during a 1931
specified period immediately preceding the enrollment date. 1932
Genetic information shall not be treated as such a condition in 1933
the absence of a diagnosis of the condition related to such 1934
information. 1935

For purposes of this division, "enrollment date" means, with 1936
respect to an individual covered under a group health benefit 1937
plan, the date of enrollment of the individual in the plan or, if 1938
earlier, the first day of the waiting period for such enrollment. 1939

(M) "Service waiting period" means the period of time after 1940
employment begins before an employee is eligible to be covered for 1941
benefits under the terms of any applicable health benefit plan 1942
offered by the small employer. 1943

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

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

(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 1975
purchase and disposition of all drugs personally furnished to 1976
patients shall be maintained by the prescriber in accordance with 1977
state and federal drug statutes and any rules adopted pursuant to 1978
those statutes. 1979

(B) When personally furnishing to a patient RU-486 1980
(mifepristone), a prescriber is subject to section 2919.123 of the 1981
Revised Code. A prescription for RU-486 (mifepristone) shall be in 1982
writing and in accordance with section 2919.123 of the Revised 1983
Code. 1984

(C)(1) Except as provided in division (D) of this section, a 1985
no prescriber ~~may not~~ shall do either of the following: 1986

(a) In any thirty-day period, personally furnish to or for 1987
patients, taken as a whole, controlled substances in an amount 1988
that exceeds a total of two thousand five hundred dosage units; 1989

(b) In any seventy-two-hour period, personally furnish to or 1990
for a patient an amount of a controlled substance that exceeds the 1991
amount necessary for the patient's use in a seventy-two-hour 1992
period. 1993

(2) The state board of pharmacy may impose a fine of not more 1994
than five thousand dollars on a prescriber who fails to comply 1995
with the limits established under division (C)(1) of this section. 1996
A separate fine may be imposed for each instance of failing to 1997
comply with the limits. In imposing the fine, the board's actions 1998
shall be taken in accordance with Chapter 119. of the Revised 1999
Code. 2000

(D)(1) None of the following shall be counted in determining 2001
whether the amounts specified in division (C)(1) of this section 2002
have been exceeded: 2003

(a) Methadone provided to patients for the purpose of 2004
treating drug dependence or addiction, if the prescriber meets the 2005

conditions specified in 21 C.F.R. 1306.07; 2006

(b) Buprenorphine provided to patients for the purpose of 2007
treating drug dependence or addiction, ~~if the prescriber is exempt~~ 2008
~~from separate registration with the United States drug enforcement~~ 2009
~~administration as part of an opioid treatment program that is the~~ 2010
~~subject of a current, valid certification from the substance abuse~~ 2011
~~and mental health services administration of the United States~~ 2012
~~department of health and human services pursuant to 21 42 C.F.R.~~ 2013
~~1301.28 8.11 and distributes both buprenorphine and methadone;~~ 2014

(c) Controlled substances provided to research subjects by a 2015
facility conducting clinical research in studies approved by a 2016
hospital-based institutional review board or an institutional 2017
review board accredited by the association for the accreditation 2018
of human research protection programs. 2019

(2) Division (C)(1) of this section does not apply to a 2020
prescriber who is a veterinarian. 2021

Sec. 4729.541. (A) Except as provided in divisions (B) and 2022
(C) of this section, a business entity described in division 2023
(B)(1)(j) or (k) of section 4729.51 of the Revised Code may 2024
possess, have custody or control of, and distribute the dangerous 2025
drugs in category I, category II, and category III, as defined in 2026
section 4729.54 of the Revised Code, without holding a terminal 2027
distributor of dangerous drugs license issued under that section. 2028

(B) If a business entity described in division (B)(1)(j) or 2029
(k) of section 4729.51 of the Revised Code is a pain management 2030
clinic or is operating a pain management clinic, the entity shall 2031
hold a license as a terminal distributor of dangerous drugs with a 2032
pain management clinic classification issued under section 2033
4729.552 of the Revised Code. 2034

(C) Beginning April 1, 2015, a business entity described in 2035

division (B)(1)(j) or (k) of section 4729.51 of the Revised Code 2036
shall hold a license as a terminal distributor of dangerous drugs 2037
in order to possess, have custody or control of, and distribute 2038
dangerous either of the following: 2039

(1) Dangerous drugs that are compounded or used for the 2040
purpose of compounding; 2041

(2) Controlled substances containing buprenorphine that are 2042
used for the purpose of treating drug dependence or addiction. 2043

Sec. 4731.056. (A) As used in this section: 2044

(1) "Controlled substance," "schedule III," "schedule IV," 2045
and "schedule V" have the same meanings as in section 3719.01 of 2046
the Revised Code. 2047

(2) "Physician" means an individual authorized by this 2048
chapter to practice medicine and surgery or osteopathic medicine 2049
and surgery. 2050

(B) The state medical board shall adopt rules in accordance 2051
with Chapter 119. of the Revised Code that establish standards and 2052
procedures to be followed by physicians in the use of controlled 2053
substances in schedule III, IV, or V to treat opioid dependence or 2054
addiction. The board may limit the application of the rules to 2055
treatment provided through an office-based practice or other 2056
practice type or location specified by the board. 2057

Section 2. That existing sections 1739.061, 1751.14, 1751.69, 2058
2329.66, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 2059
3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 2060
4729.541 of the Revised Code are hereby repealed. 2061

Section 3. (A) Not later than thirty days after the effective 2062
date of this section, the legislative authority of the fund member 2063
described in section 143.02 of the Revised Code, as enacted by 2064

this act, that maintains the police or sheriff's department shall 2065
hold the initial election of members to a volunteer peace officers 2066
dependents' fund board. A board member shall serve an initial term 2067
of office beginning on the day after the member is elected to the 2068
board and ending on the thirty-first day of December of the year 2069
in which the member is elected. Thereafter, members shall be 2070
elected to the board and serve terms of office in accordance with 2071
section 143.02 of the Revised Code, as enacted by this act. 2072

(B) For the initial election of board members specified in 2073
division (A)(2) of section 143.02 of the Revised Code, the 2074
legislative authority of the fund member that maintains the police 2075
or sheriff's department shall do both of the following: 2076

(1) Give notice of the election by posting it in a 2077
conspicuous place at the headquarters of the police or sheriff's 2078
department. Between nine a.m. and nine p.m. on the day designated, 2079
each person eligible to vote shall send in writing the name of two 2080
persons eligible to be elected to the board who are the person's 2081
choices. 2082

(2) Count and record all votes cast at the election and 2083
announce the result. The two persons receiving the highest number 2084
of votes are elected. If there is a tie vote for any two persons, 2085
the election shall be decided by lot or in any other way agreed on 2086
by the persons for whom the tie vote was cast. 2087

Section 4. This act shall have no impact on the Public 2088
Employees Retirement System, Ohio Police and Fire Pension Fund, or 2089
State Highway Patrol Retirement System. 2090

Section 5. Section 1751.14 and division (G) of section 2091
3924.01 of the Revised Code, as amended by this act, apply only to 2092
policies, contracts, and agreements that are delivered, issued for 2093
delivery, or renewed in this state on or after January 1, 2016. 2094

Division (A)(1) of section 3923.24 and division (A)(1) of section 2095
3923.241 of the Revised Code, as amended by this act, apply only 2096
to policies of sickness and accident insurance delivered, issued 2097
for delivery, or renewed in this state and public employee benefit 2098
plans or multiple employer welfare arrangement contracts and 2099
certificates that are established or modified in this state on or 2100
after January 1, 2016. 2101

Section 6. The General Assembly declares that the amendments 2102
made to section 3923.58 of the Revised Code by this act are not to 2103
supersede the suspension of the operation of this section enacted 2104
by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, 2105
it is the intent of the General Assembly to ensure consistency in 2106
Ohio Insurance Law should this suspension be nullified. 2107

Section 7. Section 2329.66 of the Revised Code is presented 2108
in this act as a composite of the section as amended by both Sub. 2109
H.B. 479 and Sub. S.B. 343 of the 129th General Assembly. The 2110
General Assembly, applying the principle stated in division (B) of 2111
section 1.52 of the Revised Code that amendments are to be 2112
harmonized if reasonably capable of simultaneous operation, finds 2113
that the composite is the resulting version of the section in 2114
effect prior to the effective date of the section as presented in 2115
this act. 2116