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Closed panel plans only through Title 17, Health Insuring Corporation	ORC 1751.02 (F)	(F) An insurer licensed under Title XXXIX of the Revised Code need not obtain a certificate of authority as a health insuring corporation to offer an open panel plan as long as the providers and health care facilities participating in the open panel plan receive their compensation directly from the insurer. If the providers and health care facilities participating in the open panel plan receive their compensation from any person other than the insurer, or if the insurer offers a closed panel plan, the insurer must obtain a certificate of authority as a health insuring corporation.
Prohibition against unfair or deceptive acts **See definitions in ORC 3901.19**	ORC 3901.20	No person shall engage in this state in any trade practice which is defined in sections 3901.19 to 3901.23 of the Revised Code as, or determined pursuant to those sections to be, an unfair or deceptive act or practice in the business of insurance.
Unfair and deceptive acts or practices in business of insurance defined **See definitions in ORC 3901.19** **Please review ORC 3901.21 in its entirety when creating the form described above. Only those sections that specifically apply to the product listed above are included here.**	ORC 3901.21	(A) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer as shown by the last preceding verified statement made by it to the insurance department of this state, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation or incomplete comparison to any person for the purpose of inducing or tending to induce such person to purchase, amend, lapse, forfeit, change, or surrender insurance. Any written statement concerning the premiums for a policy which refers to the net cost after credit for an assumed dividend, without an accurate written statement of the gross premiums, cash values, and dividends based on the insurer's current dividend scale, which are used to compute the net cost for such policy, and a prominent warning that the rate of dividend is not guaranteed, is a misrepresentation for the purposes of this division. (B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or

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		misleading. (G)(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract. (2) Nothing in division (F) or division (G)(1) of this section shall be construed as prohibiting any of the following practices: (a) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; (c) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year. (J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance. (L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder. (M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder,

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		or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever. (O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days. For purposes of division (O) of this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103. (P) Using, or permitting to be used, a pattern settlement as the basis of any offer of settlement. As used in this division, "pattern settlement" means a method by which liability is routinely imputed to a claimant without an investigation of the particular occurrence upon which the claim is based and by using a predetermined formula for the assignment of liability arising out of occurrences of a similar nature. Nothing in this division shall be construed to prohibit an insurer from determining a claimant's liability by applying formulas or guidelines to the facts and circumstances disclosed by the insurer's investigation of the particular occurrence upon which a claim is based. (Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated actuarial experience as are sighted persons. Refusal to insure includes, but is not limited to, denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the eyesight of the insured is lost. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such conditions existed at the time the policy was issued. To the extent that the provisions of this division may appear to conflict with any provision of section 3999.16 of the Revised Code, this division applies. (S) Denying coverage, under any health insurance or health care policy, contract, or plan

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		providing family coverage, to any natural or adopted child of the named insured or subscriber solely on the basis that the child does not reside in the household of the named insured or subscriber. (T)(1) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely to any health status-related factor in relation to one or more individuals, does either of the following: (a) Terminates or fails to renew an existing individual policy, contract, or plan of health benefits, or a health benefit plan issued to an employer, for which an individual would otherwise be eligible; (b) With respect to a health benefit plan issued to an employer, excludes or causes the exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits. (2) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing division (T)(1) of this section. (3) For purposes of division (T)(1) of this section, “health status-related factor” means any of the following: (a) Health status; (b) Medical condition, including both physical and mental illnesses; (c) Claims experience; (d) Receipt of health care; (e) Medical history; (f) Genetic information; (g) Evidence of insurability, including conditions arising out of acts of domestic violence; (h) Disability.

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		(U) With respect to a health benefit plan issued to a small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code. (V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code. (W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice. (X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company. (Y)(1)(a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; (b) Adding a surcharge or rating factor to a premium of any individual policy or contract of life or health insurance for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; (c) Denying coverage under, or limiting coverage under, any policy or contract of life or health insurance, for the reason that a claim under the policy or contract arises from an incident of domestic violence; (d) Inquiring, directly or indirectly, of an insured under, or of an applicant for, a policy or contract of life or health insurance, as to whether the insured or applicant is or has been a victim of domestic violence, or inquiring as to whether the insured or applicant has sought shelter or protection from domestic violence or has sought medical or psychological treatment as a victim of domestic violence. (2) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from inquiring as to, or from underwriting or rating a risk on the basis of, a person's physical or mental condition, even if the condition has been caused by domestic violence, provided that all of the following apply:

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		(a) The insurer routinely considers the condition in underwriting or in rating risks, and does so in the same manner for a victim of domestic violence as for an insured or applicant who is not a victim of domestic violence; (b) The insurer does not refuse to issue any policy or contract of life or health insurance or cancel or refuse to renew any policy or contract of life insurance, solely on the basis of the condition, except where such refusal to issue, cancellation, or refusal to renew is based on sound actuarial principles or is related to actual or reasonably anticipated experience; (c) The insurer does not consider a person's status as being or as having been a victim of domestic violence, in itself, to be a physical or mental condition; (d) The underwriting or rating of a risk on the basis of the condition is not used to evade the intent of division (Y)(1) of this section, or of any other provision of the Revised Code. (3)(a) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from refusing to issue a policy or contract of life insurance insuring the life of a person who is or has been a victim of domestic violence if the person who committed the act of domestic violence is the applicant for the insurance or would be the owner of the insurance policy or contract. (b) Nothing in division (Y)(2) of this section shall be construed to permit an insurer to cancel or refuse to renew any policy or contract of health insurance in violation of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg-41 (b), as amended, or in a manner that violates or is inconsistent with any provision of the Revised Code that implements the "Health Insurance Portability and Accountability Act of 1996." (4) An insurer is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of any action taken by the insurer to comply with division (Y) of this section. (5) As used in division (Y) of this section, "domestic violence" means any of the following acts: (a) Knowingly causing or attempting to cause physical harm to a family or household member; (b) Recklessly causing serious physical harm to a family or household member; (c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member. For the purpose of division (Y)(5) of this section, "family or household member" has the same

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		meaning as in section 2919.25 of the Revised Code. Nothing in division (Y)(5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y)(5) of this section be the basis of a criminal prosecution.
Third-party payers processing claims for payment for health care services **See definitions in ORC 3901.38** **Also see Claims Procedures section under the Federal Form Review Requirements Checklist**	ORC 3901.381	(A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section. (B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim. (2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer. The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if the third-

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		party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days. (b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days. (c) When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim. (d) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format. Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-9 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration. (3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section. It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the

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		information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division. (C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply: (1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise. (2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise. (D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer. (E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section. (F) A third party payer shall transmit electronically any payment with respect to claims that the third party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.
Electronic submission of claims **See definitions in ORC 3901.38** **Also see Claims Procedures section**	ORC 3901.382	Beginning six months after the date specified in section 262 of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 2027, 42 U.S.C.A. 1320d-4, on which a third-party payer is initially required to comply with a standard or implementation specification for the electronic exchange of health information, as adopted or established by the United States secretary of health and human services pursuant to that act, sections 3901.381, 3901.384, 3901.385, 3901.389, 3901.3810, 3901.3811, 3901.3812, and 3901.3813 of the Revised Code apply to a claim submitted to a third-party payer for payment for health care services only if the claim is submitted electronically. A provider and third-party payer may enter into a contractual arrangement under which the third-party payer agrees to process claims that are not submitted electronically because of the financial hardship that electronic submission of claims would create

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under the Federal Form Review Requirements Checklist		for the provider or any other extenuating circumstance.
Untimely claim process See definitions in ORC 3901.38 Also see Claims Procedures section under the Federal Form Review Requirements Checklist	ORC 3901.384	(A) Subject to division (B) of this section, a third-party payer that requires timely submission of claims for payment for health care services shall process a claim that is not submitted in a timely manner if a claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits and that payer or program has determined that it is not responsible for the cost of the health care services. When a claim is submitted later than one year after the last date of service for which reimbursement is sought under the claim, the third-party payer shall pay or deny the claim not later than ninety days after receipt of the claim or, alternatively, pursuant to the requirements of sections 3901.381 to 3901.388 of the Revised Code. The third-party payer must make an election to process such claims either within the ninety-day period or under section 3901.381 of the Revised Code. If the claim is denied, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim. (B) The third-party payer may refuse to process a claim submitted by a provider if the provider submits the claim later than forty-five days after receiving notice from the different third-party payer or a state or federal program that that payer or program is not responsible for the cost of the health care services, or if the provider does not submit the notice of denial from the different third-party payer or program with the claim. The failure of a provider to submit a notice of denial in accordance with this division shall not affect the terms of a benefits contract. (C) For purposes of this section, both of the following apply: (1) A determination that a third-party payer or state or federal program is not responsible for the cost of health care services includes a determination regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, subrogation provisions, and similar findings; (2) State and federal programs that offer health care benefits include medicare, medicaid, workers' compensation, the civilian health and medical program of the uniformed services and other elements of the tricare program offered by the United States department of defense, and similar state or federal programs. (D) Any provision of a contractual arrangement entered into between a third-party payer and a

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		provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.
Prohibited practices by third party payers **See definitions in ORC 3901.38** **Also see Claims Procedures section under the Federal Form Review Requirements Checklist**	ORC 3901.385	A third-party payer shall not do either of the following: (A) Engage in any business practice that unfairly or unnecessarily delays the processing of a claim or the payment of any amount due for health care services rendered by a provider to a beneficiary; (B) Refuse to process or pay within the time periods specified in section 3901.381 of the Revised Code a claim submitted by a provider on the grounds the beneficiary has not been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.
Reimbursement contract - reimbursements to be made directly to hospital - assignment of benefits **See definitions in ORC 3901.38** **Also see Claims Procedures section under the Federal Form Review Requirements Checklist**	ORC 3901.386	(A) Notwithstanding section 1751.13 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into or renewed on or after June 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital. (B) If the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement of covered services, the third-party payer shall accept and honor a completed and validly executed assignment of benefits with a hospital by a beneficiary, except when the third-party payer has notified the hospital in writing of the conditions under which the third-party payer will not accept and honor an assignment of benefits. Such notice shall be made annually. (C) A third-party payer may not refuse to accept and honor a validly executed assignment of benefits with a hospital pursuant to division (B) of this section for medically necessary hospital services provided on an emergency basis.

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Payments considered final – overpayment **See definitions in ORC 3901.38** **Also see Claims Procedures section under the Federal Form Review Requirements Checklist**	ORC 3901.388	(A) A payment made by a third-party payer to a provider in accordance with sections 3901.381 to 3901.386 of the Revised Code shall be considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider. (B) A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. The third-party payer shall inform the provider of its determination of overpayment by providing notice in accordance with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment. When a provider has failed to make a timely response to the notice of the third-party payer's determination of overpayment, the third-party payer may recover the overpayment by deducting the amount of the overpayment from other payments the third-party payer owes the provider or by taking action pursuant to any other remedy available under the Revised Code. When a provider elects not to appeal a determination of overpayment or appeals the determination but the appeal is not upheld, the third-party payer shall permit a provider to repay the amount by making one or more direct payments to the third-party payer or by having the amount deducted from other payments the third-party payer owes the provider. (C) The notice of overpayment a third-party payer is required to give a provider under division (B) of this section shall be made in writing and shall specify all of the following: (1) The full name of the beneficiary who received the health care services for which overpayment was made; (2) The date or dates the services were provided; (3) The amount of the overpayment; (4) The claim number or other pertinent numbers; (5) A detailed explanation of basis for the third-party payer's determination of overpayment; (6) The method in which payment was made, including, for tracking purposes, the date of

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		payment and, if applicable, the check number; (7) That the provider may appeal the third-party payer's determination of overpayment, if the provider responds to the notice within thirty days; (8) The method by which recovery of the overpayment would be made, if recovery proceeds under division (B) of this section. (D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.
Computation of interest **See definitions in ORC 3901.38** **Also see Claims Procedures section under the Federal Form Review Requirements Checklist**	ORC 3901.389	(A) Any third-party payer that fails to comply with section 3901.381 of the Revised Code, or any contractual payment arrangement entered into under section 3901.383 of the Revised Code, shall pay interest in accordance with this section. (B) Interest shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with section 3901.381 of the Revised Code or the contractual payment arrangement entered into under section 3901.383 of the Revised Code, and the date payment is made. The interest rate for determining the amount of interest due shall be equal to an annual percentage rate of eighteen per cent. (C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a payment was made by the third-party payer, both of the following apply: (1) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider by mail and retains a record of the day the payment was mailed, there exists a rebuttable presumption that the payment was made five business days before the day the payment was received by the provider, unless it can be proven otherwise. (2) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider electronically, there exists a rebuttable presumption that the payment was made twenty-four hours before the date the payment was received by the provider, unless it can be proven otherwise. (D) Interest due in accordance with this section shall be paid directly to the provider at the time payment of the claim is made and shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

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Effect of sexual orientation, HIV, or AIDS or related condition **Also see Pre-Existing section of the Federal Form Review Requirements Checklist**	ORC 3901.45 (D)(E)(F)(G)	(D)(1) Except as provided in division (D)(2) of this section, no insurer shall cancel a policy of life or sickness and accident insurance, or refuse to renew a policy of life or sickness and accident insurance other than a policy that is renewable at the option of the insurer, based solely on the fact that, after the effective date of the policy, the policyholder is diagnosed as having AIDS, an AIDS-related condition, or an HIV infection. (2) If a policy of life or sickness and accident insurance provides for a contestability period, an insurer may cancel the policy during the contestability period if the applicant made a false statement in the application with regard to the question of whether he has been diagnosed as having AIDS, an AIDS-related condition, or an HIV infection. (E) No insurer shall deliver, issue for delivery, or renew a policy of life or sickness and accident insurance that limits benefits or coverage in the event that, after the effective date of the policy, the insured develops AIDS or an AIDS-related condition or receives a positive result on an HIV test. (F) An insurer is not required to offer coverage under a policy of life or sickness and accident insurance to an individual or group member, or a dependent of an individual or group member, who has AIDS or an AIDS-related condition, or who has had a positive result on an HIV test. (G) An insurer is not required to continue to provide coverage under a policy of life or sickness and accident insurance to an individual or group member, or a dependent of an individual or group member, if the insurer determines the individual or group member or dependent of the individual or group member knew on the effective date of the policy that he had AIDS, an AIDS-related condition, or a positive result of an HIV test.
Genetic screening or testing **Also see Genetic Testing (GINA) section of the Federal Form Review**	ORC 3901.491	(A) As used in this section: (1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

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Requirements Checklist		(2) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance. (3) "Sickness and accident insurance" means sickness and accident insurance under Chapter 3923 of the Revised Code excluding disability income insurance and excluding supplemental policies of sickness and accident insurance. (B) Upon the repeal of section 3901.49 of the Revised Code , no insurer shall do either of the following: (1) Consider any information obtained from genetic screening or testing in processing an application for an individual or group policy of sickness and accident insurance, or in determining insurability under such a policy; (2) Inquire, directly or indirectly, into the results of genetic screening or testing or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, a sickness and accident insurance policy. (C) Any insurer that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.
Policies to which section apply – exceptions **See definitions in ORC 3902.02**	ORC 3902.03 (A)	(A) Sections 3902.01 to 3902.08 of the Revised Code apply to all policies delivered or issued for delivery in this state by any company on or after the date such forms must be approved under sections 3902.01 to 3902.08 of the Revised Code. Sections 3902.01 to 3902.08 of the Revised Code do not apply to: (1) Any policy that is a security subject to federal jurisdiction; (2) Any group policy, other than a group credit life insurance policy, or a group credit disability insurance policy. This division does not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state. (3) Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans; (4) Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved, or permitted to be issued prior to the dates such forms must be approved pursuant to

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		sections 3902.01 to 3902.08 of the Revised Code; (5) The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under sections 3902.01 to 3902.08 of the Revised Code.
Coordination of benefits - Status of health coverage **See definitions in ORC 3902.11**	ORC 3902.12	When a plan of health coverage is primary, its benefits are paid without regard to the benefits of another plan. When a plan of health coverage is secondary, its benefits are determined by taking into consideration the payments made or to be made by another plan. When there are more than two plans, a plan may be primary as to one and may be secondary as to another.
Coordination of benefits - Determination of order; secondary plan as excess; excess or duplicate payments **See definitions in ORC 3902.11**	ORC 3902.13	(A) A plan of health coverage determines its order of benefits using the first of the following that applies: (1) A plan that does not coordinate with other plans is always the primary plan. (2) The benefits of the plan that covers a person as an employee, member, insured, or subscriber, other than a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan. (3) When more than one plan covers the same child as a dependent of different parents who are not divorced or separated, the primary plan is the plan of the parent whose birthday falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan that covered the parent the longer is the primary plan. The plan that covered the parent the shorter time is the secondary plan. If the other plan's provision for coordination of benefits does not include the rule contained in this division because it is not subject to regulation under this division, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits. (4)(a) Except as provided in division (A)(4)(b) of this section, if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order: (i) The plan of the parent who is the residential parent and legal custodian of the child; (ii) The plan of the spouse of the parent who is the residential parent and legal custodian of the

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		child; (iii) The plan of the parent who is not the residential parent and legal custodian of the child. (b) If the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is the primary plan. A parent responsible for the health care pursuant to a court decree must notify the insurer or health insuring corporation of the terms of the decree. (5) The primary plan is the plan that covers a person as an employee who is neither laid off or retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or that employee's dependent. (6) If none of the rules in divisions (A)(1), (2), (3), (4), and (5) of this section determines the order of benefits, the primary plan is the plan that covered an employee, member, insured, or subscriber longer. The secondary plan is the plan that covered that person the shorter time. (B) When a plan of health coverage is determined to be a secondary plan it acts to provide benefits in excess of those provided by the primary plan. (C) The secondary plan shall not be required to make payment in an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of expenses allowable under the provisions of the applicable policies and contracts. (D) A third-party payer may require a beneficiary to file a claim with the primary plan before it determines the amount of its payment obligation, if any, with regard to that claim. (E) Nothing in this section shall be construed to require a plan to make a payment until it determines whether it is the primary plan or the secondary plan and what benefits are payable under the primary plan. (F) A plan may obtain any facts and information necessary to apply the provisions of this section, or supply this information to any other third-party payer or provider, or any agent of such third-party payer or provider, without the consent of the beneficiary. Each person claiming benefits under the plan shall provide any information necessary to apply the provisions of this section. (G) If the amount of payments made by any plan is more than should have been paid, the plan

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		may recover the excess from whichever party received the excess payment. (H) No third-party payer shall administer a plan of health coverage delivered, issued for delivery, or renewed on or after June 29, 1988, unless such plan complies with this section. (I)(1) A third-party payer that is subject to this section and has reason to believe payment has been made by another third-party payer for the same service may request from that third-party payer, and shall be provided by the third-party payer, such data as necessary to determine whether duplicate payment has been made. (2) A third-party payer that meets the criteria of a secondary payer in accordance with this section may seek repayment of any duplicate payment that may have been made from the person to whom it made payment. If the person who received the duplicate payment is a provider, absent a finding of a court of competent jurisdiction that the provider has engaged in civil or criminal fraudulent activities, the request for the return of any duplicate payment shall be made within three years after the close of the provider's fiscal year in which the duplicate payment has been made. (J) Nothing in this section shall be construed to affect the prohibition of section 3923.37 of the Revised Code. (K)(1) No third-party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section. (2) No primary plan shall direct or encourage an insured to use the benefits of a secondary plan that results in a reduction of payment by such primary plan.
Insurance information practices – applicability of chapter **See definitions in ORC 3904.01**	ORC 3904.02	(A) The obligations of sections 3904.01 to 3904.22 of the Revised Code apply to those insurance institutions, agents, or insurance support organizations that, on or after the effective date of these sections, do either of the following: (1) Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this state; (2) Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state. (B) The rights granted by sections 3904.01 to 3904.22 of the Revised Code extend to both of

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		the following persons who are residents of this state: (1) Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; (2) Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions. (C) For purposes of this section, a person is considered a resident of this state if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance support organization, is located in this state.
Insurance information practices - notice to applicants and policyholders **<u>See definitions in ORC 3904.01</u>**	ORC 3904.04	(A) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below: (1) In the case of an application for insurance, a notice shall be provided no later than one of the following times: (a) At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; (b) At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records. (2) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if either of the following apply: (a) Personal information is collected only from the policyholder or from public records; (b) A notice meeting the requirements of this section has been given within the previous twenty-four months. (3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records. (B) The notice required by division (A) of this section shall be in writing and shall state all of the

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		following: (1) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage; (2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information; (3) The types of disclosures identified in divisions (B), (C), (D), (E), (F), (I), (K), (L), and (N) of section 3904.13 of the Revised Code and the circumstances under which such disclosures may be made without prior authorization. However, only those circumstances need be described that occur with such frequency as to indicate a general business practice; (4) A description of the rights established under sections 3904.08 and 3904.09 of the Revised Code and the manner in which such rights may be exercised; (5) That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons. (C) In lieu of the notice prescribed in division (B) of this section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder of all of the following: (1) Personal information may be collected from persons other than the individual or individuals proposed for coverage; (2) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization; (3) A right of access and correction exists with respect to all personal information collected; (4) The notice prescribed in division (B) of this section will be furnished to the applicant or policyholder upon request. (D) The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

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Copies of application to accompany policies issued – Life insurance companies	ORC 3911.04	Every life insurance company doing business in this state shall return with, and as part of any policy issued by it, to any person taking such policy, a complete copy of each application or other document held by it which is intended in any manner to affect the force or validity of such policy. A company which neglects to do so is estopped from denying the truth of any such application or other document, so long as it is in default for such copy. In case such company neglects for thirty days after demand made therefor, to furnish such copies, it is forever barred from setting up as a defense to any suit on the policy, and incorrectness or want of truth of such application or other document.
Policy of sickness and accident insurance defined	ORC 3923.01	As used in this chapter, "policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after the effective date of this amendment.
Sickness and accident insurance definitions	ORC 3923.011	As used in any policy of sickness and accident insurance delivered, issued for delivery, or used in this state, unless otherwise provided in the policy or in an indorsement thereon or in a rider attached thereto: (A) "Total disability" means inability to perform the duties of any gainful occupation for which the insured is reasonably fitted by training, experience, and accomplishment. (B) "Confinement to house" includes the activities of a convalescent not able to be gainfully employed. (C) "Accidental death" means death by accident exclusively and independently of all other causes.
Validity of nonconforming policy	ORC 3923.09	A policy of sickness and accident insurance issued in violation of sections 3923.01 to 3923.22, inclusive, of the Revised Code, is valid but shall be construed as provided by such sections, and when any provision in such policy is in conflict with such sections, the rights, duties, and obligations of the insurer, the policyholder, and the beneficiary shall be governed by such sections.

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Group sickness and accident insurance – inspection requirements	ORC 3923.12 (D)	(D) Each such policy together with any application in connection therewith shall be available for inspection at all reasonable times at the place of business or principal residence of the policyholder where the policy is on file, by any beneficiary thereunder, or by an authorized representative of the beneficiary.
Option for conversion from group policy to individual policy – additional requirements	ORC 3923.122 (E) (F) (G)(I)(J)(K)(L)(M)(N)	Suspended effective 1/1/2014 through 1/1/2018 (Ohio Senate Bill 9, 130TH GA)
False statement in application - alteration of written application	ORC 3923.14	The falsity of any statement in the application for any policy of sickness and accident insurance shall not bar the right to recovery thereunder, or be used in evidence at any trial to recover upon such policy, unless it is clearly proved that such false statement is willfully false, that it was fraudulently made, that it materially affects either the acceptance of the risk or the hazard assumed by the insurer, that it induced the insurer to issue the policy, and that but for such false statement the policy would not have been issued. No alteration of any written application for any such policy, by erasure, insertion, or otherwise, shall be made by any person other than the applicant without the written consent of said applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.
Unfair discrimination prohibited	ORC 3923.15	No insurer doing the business of sickness and accident insurance in this state shall make or permit any unfair discrimination between individuals of substantially the same hazard in the amount of premium rates charged for any policy or contract of such insurance or in the benefits payable thereunder. This section does not prohibit different premium rates, different benefits, or different underwriting procedure for individuals insured under group, franchise, or blanket plans of insurance, or for individuals insured under a policy issued to the head of a family as provided in section 3923.03 of the Revised Code.
Prohibition of rebates not to prohibit commissions or dividends	ORC 3923.17	The laws of this state prohibiting rebates do not prohibit any of the following: (A) The payment of a commission or other compensation to any licensed agent or broker; (B) Any insurer from allowing or returning to its participating policyholders dividends, savings, or unused premium deposits; (C) Any insurer from returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance;

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		(D) The taking of a bona fide obligation, with interest at a rate not exceeding six per cent per annum, in the payment of any premium.
Hospitalization coverage for mental illness **Also see Mental Health and Substance Use Disorder Parity section under the Federal Form Review Requirements Checklist**	ORC 3923.27	No policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state after August 26, 1976, including both individual and group policies, that provides hospitalization coverage for mental illness shall exclude such coverage for the reason that the insured is hospitalized in an institution or facility receiving tax support from the state, any municipal corporation, county, or joint county board, whether such institution or facility is deemed charitable or otherwise, provided the institution or facility or portion thereof is fully accredited by the joint commission on accreditation of hospitals or certified under Titles XVIII and XIX of the "Social Security Act of 1935," 79 Stat. 291, 42 U.S.C.A. 1395, as amended. The insurance coverage shall provide payment amounting to the lesser of either the full amount of the statutory charge for the cost of the services pursuant to section 5121.33 of the Revised Code or the benefits payable for the services under the applicable insurance policy. Insurance benefits for the coverage shall be paid so long as patients and their liable relatives retain their statutory liability pursuant to section 5121.33 of the Revised Code. Only that portion or per cent of the benefits shall be payable that has been assigned, or ordered to be paid, to the state or other appropriate provider for services rendered by the institution or facility.
Prohibiting exclusion or reduction of benefits because benefits payable under supplemental policy	ORC 3923.37	(A) No individual or group sickness and accident insurance policy shall be delivered, issued for delivery, or renewed in this state that excludes or reduces the benefits payable to or on behalf of an insured because benefits are also payable or have been paid under a supplemental sickness and accident policy to which all of the following apply: (1) The policy covers a specified disease or a limited plan of coverage. (2) The policy is specifically designed, advertised, represented, and sold as a supplement to other basic sickness and accident insurance coverage. (3) The entire premium for the policy is paid by the insured, the insured's family, or the insured's guardian. (B) This section applies to supplemental sickness and accident policies irrespective of the mode or channel of premium payment to the insurer or of any reduction in the premium by virtue of the insured's membership in any organization or the insured's status as an employee.

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Continuing policy upon termination of employment – additional requirements	ORC 3923.38 (D)(E)	(D) This section does not apply to an employer's self-insurance plan if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans. (E) An employer shall notify the insurer if the employee elects continuation of coverage under this section. The insurer may require the employer to provide documentation if the employee elects continuation of coverage and is seeking premium assistance for the continuation of coverage under the "American Recovery and Investment Act of 2009," Pub. L. No. 111-5 , 123 Stat. 115. The director of insurance shall publish guidance for employers and insurers regarding the contents of such documentation.
Continuing coverage under group policy when reservist is called or ordered to active duty – additional requirements	ORC 3923.381 (H)(I)	(H)(1) No insurer shall fail to provide for a continuation of coverage, or an extension of a continuation of coverage, in a group policy as required by and in accordance with the terms and conditions set forth under this section. (2) No insurer shall fail to issue a certificate of coverage in compliance with division (D)(3) of this section. (3) No employer shall fail to provide an employee or eligible person with notice of the right to a continuation of coverage under a group policy in accordance with division (D)(2) of this section. (I) Whoever violates division (H)(1), (2), or (3) of this section is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.
Prescription drug limitations or exclusions	ORC 3923.60 (D)	(D) Division (A) of this section shall not be construed to do any of the following: (1) Require coverage for any drug if the United States food and drug administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed; (2) Require coverage for experimental drugs not approved for any indication by the United States food and drug administration; (3) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States food and drug administration; (4) Require reimbursement or coverage for any drug not included in the drug formulary or list of

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		covered drugs specified in a policy of sickness and accident insurance; (5) Prohibit a policy of sickness and accident insurance from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.
Disclosing determination of usual and customary fee for dental benefits	ORC 3923.62	(A) Each insurer that delivers, issues for delivery, or renews individual or group sickness and accident insurance policies providing dental benefits, and that bases payment for those benefits on a usual and customary fee charged by dentists, and each administrator of a self-insured dental plan that bases payment for dental benefits on a usual and customary fee charged by dentists, shall disclose all of the following in accordance with division (B) of this section: (1) The frequency of the determination of the usual and customary fee; (2) A general description of the methodology used to determine usual and customary fees; (3) The geographic area used to determine usual and customary fees; (4) If the usual and customary fee for a service is determined by taking a sample of fees submitted on actual claims from dentists and then selecting a percentile of those fees, the percentile that is used by the insurer. (B) The insurer or administrator shall disclose the information described in division (A) of this section to a policyholder, certificate holder, or participant of a self-insured plan, if requested by the policyholder, certificate holder, or participant. The disclosure shall be made within thirty days after the insurer or administrator receives the request from the policyholder, certificate holder, or participant. (C) A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. (D) As used in this section, “administrator” means a person who is licensed under Chapter 3959 of the Revised Code.

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Coverage of inpatient care and follow-up for mother and her newborn **Also see Newborns' and Mothers' coverage section under the Federal Form Review Requirements Checklist**	ORC 3923.63 (C)(D)	(C)(1) No sickness and accident insurer may do either of the following: (a) Terminate the participation of a health care professional or health care facility as a provider under a sickness and accident insurance policy solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section; (b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section. (2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. (D) This section does not do any of the following: (1) Require a policy to cover inpatient or follow-up care that is not received in accordance with the policy's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services; (2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery; (3) Require a child to be delivered in a hospital or other inpatient setting; (4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code; (5) Establish minimum standards of medical diagnosis, care or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.113 of the Revised Code.
Coverage for alcohol or drug related losses or expenses	ORC 3923.82	A) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code. (B) Notwithstanding section 3901.71 of the Revised Code, no health benefit plan or public

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		employee benefit plan shall contain a provision that limits or excludes an insured's coverage under the plan for a loss or expense the insured sustains that is the result of the insured's use of alcohol or other drugs or both and the loss or expense is otherwise covered under the plan. (C) Nothing in this section shall be construed as doing either of the following: (1) Requiring coverage for the treatment of alcohol or substance abuse except as otherwise required by law; (2) Prohibiting the enforcement of an exclusion based on injuries sustained by an insured during the commission of an offense by the insured in which the insured is convicted of or pleads guilty or no contest to a felony.
Health care benefit plans covered by chapter – eligibility **See definitions in ORC 3924.01**	ORC 3924.02 (A)	(A) An individual or group health benefit plan is subject to sections 3924.01 to 3924.14 of the Revised Code if it provides health care benefits covering at least two but no more than fifty employees of a small employer, and if it meets either of the following conditions: (1) Any portion of the premium or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium. (2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of section 106 or 162 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.
Health care benefit plans covered by chapter – applicable law **See definitions in ORC 3924.01**	ORC 3924.02 (C)(D)	(C) Every health benefit plan offered or delivered by a carrier, other than a health insuring corporation, to a small employer is subject to sections 3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and any other provision of the Revised Code that requires the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner. (D) Except as expressly provided in sections 3924.01 to 3924.14 of the Revised Code, no health benefit plan offered to a small employer is subject to any of the following: (1) Any law that would inhibit any carrier from contracting with providers or groups of providers

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		with respect to health care services or benefits; (2) Any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan; (3) Any law that would require any carrier to either include a specific provider or class of provider when contracting for health care services or benefits, or to exclude any class of provider that is generally authorized by statute to provide such care.
Health care benefit plans covering small employers subject to conditions – exclusions and riders **See definitions in ORC 3924.01**	ORC 3924.03 (C)(D)	(C) A carrier shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan, on the basis of any actual or expected health condition of the employee or dependent. If, prior to November 24, 1995, a carrier excluded an eligible employee or dependent, other than a late enrollee, on the basis of an actual or expected health condition, the carrier shall, upon the initial renewal of the coverage on or after that date, extend coverage to the employee or dependent if all other eligibility requirements are met. (D) No health benefit plan issued by a carrier shall limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for pre-existing conditions as permitted under division (A) of this section. If a health benefit plan that is delivered or issued for delivery prior to April 14, 1993, contains such limitations or exclusions, by use of a rider or amendment applicable to a specific individual, the plan shall eliminate the use of such riders or amendments within eighteen months after April 14, 1993.
Health care benefit plans covering small employers subject to conditions – benefit structure, information collected, definition of bona fide association **See definitions in ORC**	ORC 3924.03 (F) (G)	(F) The benefit structure of any health benefit plan may, at the time of coverage renewal, be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans being marketed to new small employer groups. If the health benefit plan is available in the small employer market other than only through one or more bona fide associations, the modification must be consistent with the law of this state and effective on a uniform basis among small employer group plans. (G) A carrier may obtain any facts and information necessary to apply this section, or supply those facts and information to any other third-party payer, without the consent of the

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3924.01		beneficiary. Each person claiming benefits under a health benefit plan shall provide any facts and information necessary to apply this section. For purposes of this section, "bona fide association" means an association that has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to an individual, including an employee or dependent; makes health insurance coverage offered through the association available to all members regardless of any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to such members or to individuals eligible for coverage through a member; does not make health insurance coverage offered through the association available other than in connection with a member of the association; and meets any other requirement imposed by the superintendent. To maintain its status as a "bona fide association," each association shall annually certify to the superintendent that it meets the requirements of this paragraph.
Carriers offering health benefit plan in small employer market through network plan **See definitions in ORC 3924.01**	ORC 3924.031	(A) As used in this section and section 3924.032 of the Revised Code: (1) "Health status-related factor" means any of the following: (a) Health status; (b) Medical condition, including both physical and mental illnesses; (c) Claims experience; (d) Receipt of health care; (e) Medical history; (f) Genetic information; (g) Evidence of insurability, including conditions arising out of acts of domestic violence; (h) Disability. (2) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in

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		whole or in part, through a defined set of providers under contract with the carrier. (B) If a carrier offers a health benefit plan in the small employer market through a network plan, the carrier may do both of the following: (1) Limit the small employers that may apply for such coverage to those with eligible employees who live, work, or reside in the service area of the network plan; (2) Within the service area of the network plan, deny the coverage to small employers if the carrier has demonstrated both of the following to the superintendent of insurance: (a) The carrier will not have the capacity to deliver services adequately to the members of any additional groups because of the carrier's obligations to existing group contract holders and members. (b) The carrier is applying division (B)(2) of this section uniformly to all small employers without regard to the claims experience of those employers and their eligible employees and dependents or to any health status-related factor relating to such employees and dependents. (C) A carrier that, pursuant to division (B)(2) of this section, denies coverage to a small employer in the service area of a network plan, shall not offer coverage in the small employer market within that service area for at least one hundred eighty days after the date the coverage is denied.
Refusing to issue plans in small employer market **See definitions in ORC 3924.01** **Also see the Guaranteed Available section of the Federal Form Review Requirements Checklist**	ORC 3924.032	(A) A carrier may refuse to issue health benefit plans in the small employer market if the carrier has demonstrated both of the following to the superintendent of insurance: (1) The carrier does not have the financial reserves necessary to underwrite additional coverage. (2) The carrier is applying division (A) of this section uniformly to all employers in the small employer market in this state consistent with the applicable laws and rules of this state and without regard to the claims experience of those employers and their employees and dependents or to any health status-related factor relating to such employees and dependents. (B) A carrier that, pursuant to division (A) of this section, refuses to issue health benefit plans in the small employer market, shall not offer health benefit plans in the small employer market in this state for at least one hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves

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		to underwrite additional coverage, whichever is later. (C) The superintendent may provide for the application of this section on a service-area-specific basis.
Information disclosed by carrier to the employer **See definitions in ORC 3924.01**	ORC 3924.033	(A) Each carrier, in connection with the offering of a health benefit plan to a small employer, shall disclose to the employer, as part of its solicitation and sales materials, the following information: (1) The provisions of the plan concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; (2) The provisions of the plan relating to renewability of coverage; (3) The provisions of the plan relating to any pre-existing condition exclusion; (4) The benefits and premiums available under all health benefit plans for which the employer is qualified. (B) The information described in division (A) of this section shall be provided in a manner determined to be understandable by the average small employer, and in a manner sufficient to reasonably inform a small employer regarding the employer's rights and obligations under the health benefit plan. (C) Nothing in this section requires a carrier to disclose any information that is by law proprietary and trade secret information.
Prohibiting exclusion based on health condition	ORC 3924.25	(A) As used in this section, "employer" means any person who employs an individual. (B) No employer shall engage in any act or practice that, due solely to the actual or expected health condition of one or more individuals, excludes or causes the exclusion of any individual from coverage under an existing employer-provided policy, contract, or plan of health benefits for which the individual would otherwise be eligible. (C) If an employer violates division (B) of this section, the prosecuting attorney of the county in which an individual who was excluded from benefits resides may commence a civil action in the court of common pleas to obtain a judgment for a civil penalty as described in this division. If the court of common pleas determines in an action under this division that an employer violated division (B) of this section, it shall impose a civil penalty of not more than ten thousand dollars or, if the violator previously has been determined by any court of common pleas to have

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		violated division (B) of this section, not more than twenty-five thousand dollars. Any civil penalty imposed pursuant to this division shall be deposited by the clerk of the court into the county treasury.
Prohibiting consideration of eligibility for medical assistance	ORC 3924.41	(A) As used in sections 3924.41 and 3924.42 of the Revised Code, "health insurer" means any sickness and accident insurer or health insuring corporation. "Health insurer" also includes any group health plan as defined in section 607 of the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1167. (B) Notwithstanding any other provision of the Revised Code, no health insurer shall take into consideration the availability of, or eligibility for, the medicaid program in this state or in any other state when determining an individual's eligibility for coverage or when making payments to or on behalf of an enrollee, subscriber, policyholder, or certificate holder. (
Prohibiting imposing different requirements on department of Medicaid	ORC 3924.42	No health insurer shall impose requirements on the department of medicaid, when it has been assigned the rights of an individual who is eligible for medicaid and who is covered under a health care policy, contract, or plan issued by the health insurer, that are different from the requirements applicable to an agent or assignee of any other individual so covered.
Prohibiting denial of enrollment of certain children	ORC 3924.46	A) As used in sections 3924.46 to 3924.49 of the Revised Code, “health insurer” has the same meaning as in section 3924.41 of the Revised Code. (B) No health insurer shall deny enrollment of a child under the health plan of the child’s parent on the basis that any of the following applies: (1) The child was born out of wedlock. (2) The child is not claimed as a dependent on the federal tax return of the parent. (3) The child does not reside in the household of the parent, or in the service area of the health insurer.

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Duties of health insurer of noncustodial parent	ORC 3924.47	If a child has health care coverage through a health insurer of a noncustodial parent, the health insurer shall do all of the following: (A) Provide such information to the custodial parent of the child as may be necessary for the child to obtain benefits through the coverage; (B) Permit the custodial parent, or a provider with the approval of the custodial parent, to submit claims for covered services without the approval of the noncustodial parent; (C) Make payment on claims submitted in accordance with division (B) of this section directly to the custodial parent, the provider, or the department of job and family services.
Parent required by court or administrative order to provide health care coverage for child – duties of health insurer	ORC 3924.48	(A) If a parent of a child is required by a court or administrative order to provide health care coverage for the child, and if the parent is eligible for family health care coverage provided by a health insurer, the health insurer shall do both of the following: (1) If the child is otherwise eligible for the coverage, permit the parent to enroll the child under the family coverage without regard to any enrollment period restrictions; (2) If the parent is enrolled under the coverage but fails to make application to obtain coverage for the child, enroll the child under the family coverage upon application of the child's other parent or pursuant to a child support order containing provisions in compliance with sections 3119.29 to 3119.56 of the Revised Code. (B) The health insurer shall not terminate the child's coverage unless the health insurer is provided satisfactory written evidence of either of the following: (1) The court or administrative order is no longer in effect. (2) The child is or will be enrolled under comparable health care coverage provided by another health insurer, which coverage will take effect not later than the effective date of the termination of the current coverage. (C) As used in this section, "child support order" has the same meaning as in section 3119.01 of the Revised Code.
Life and Health Insurance Guaranty Association – prohibitions and notice	ORC 3956.18 (A)(D)	(A)(1) No person shall make, publish, disseminate, circulate, or place before the public, or cause to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other manner, any advertisement, announcement, or statement, written or oral, that uses the existence of the Ohio life and health insurance

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Also see definitions in ORC 3956.01		guaranty association for the purposes of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter. (2) As used in division (A)(1) of this section, "person" includes but is not limited to any insurer or any agent or affiliate of any insurer. (3) Division (A)(1) of this section does not apply to the association or any other entity that does not sell or solicit insurance. (D) No insurer or agent may deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code, all or a portion of which is excluded under division (B)(2)(a) of section 3956.04 of the Revised Code from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract, or a portion of the policy or contract, is not covered by the association. The superintendent, by rule, shall specify the form and content of the notice.
Unfair trade practices	OAC 3901-1-07	(A) Authority Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code. (B) Purpose Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section. The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith. (C) Defined unfair practices It shall be deemed an unfair or deceptive practice to commit or perform with such frequency as to indicate a general business practice any of the following: (1) Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to

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		coverage at issue; (a) Misrepresenting a pertinent policy provision by making any payment, settlement, or offer of first party benefits, which, without explanation, does not include all amounts which should be included according to the claim filed by the first party claimant and investigated by the insurer; (b) Denying a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion; (2) Failing to acknowledge pertinent communications with respect to claims arising under insurance policies in writing, or by other means so long as an appropriate notation is made in the claim file of the insurer, within fifteen days of receiving notice of a claim in writing or otherwise; (3) Failing to make an appropriate reply within twenty-one days of all other pertinent communications and/or any inquiries of the department of insurance respecting a claim; (4) Failing to adopt and implement reasonable procedures to commence an investigation of any claim filed by either a first party or third party claimant, or by such claimant's authorized representative, within twenty-one days of receipt of notice of claim; (5) Failing to mail or furnish claimant or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen days of receiving notice of claim, unless the insurer, based on the information then in its possession does not yet know all such requirements, then such notification shall be sent, within a reasonable time; (6) Not offering first party or third party claimants, or their authorized representatives who have made claims which are fair and reasonable and in which liability has become reasonably clear, amounts which are fair and reasonable as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions; (7) Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered; (8) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or

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		compromises less than the amount awarded in arbitration; (9) Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge, or consent of insureds; (10) Attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application; (11) Attempting to delay the investigation or payment of claims by requiring an insured and his physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (12) Failing to advise the first party claimant or the claimant's authorized representative, in writing or by other means so long as an appropriate notation is made in the claim file of the insurer, of the acceptance or rejection of the claim, within twenty-one days after receipt by the insurer of a properly executed proof of loss; (a) Failing to notify such claimant or the claimant's authorized representative, within twenty-one days after receipt of such proof of loss, that the insurer needs more time to determine whether the claim should be accepted or rejected; (b) Failing to send a letter to such claimant or, the claimant's authorized representative, stating the need for further time to investigate the claim, if such claim remains unsettled ninety days from the date of the initial letter setting forth the need for further time to investigate; (c) Failing to send to such claimant or authorized representative every ninety days after the first ninety-day claim investigation period, a letter setting forth the reasons additional time is needed for investigation, unless the delay is caused by factors beyond the insurer's control; (13) Failing to advise such claimant or claimant's authorized representative, of the amount offered, if such claim is accepted in whole or in part; (14) Refusing payments of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information; (15) Failing to adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or

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		claimants; (16) Failing to pay any amount finally agreed upon in settlement of all or part of any claim or authorized repairs to be made upon final agreement not later than five days from the receipt of such agreement by the insurer at the place from which the payment or authorization is to be made or from the date of the performance by the claimant of any condition set by such agreement, whichever is later. (17) For purposes of this rule, the following definitions shall apply; (a) "Investigation" shall mean all activities of the company related directly or indirectly to the determining of liabilities under the coverages afforded by the policy. This shall include, but not be limited to, a bona fide effort to contact all insureds and claimants within a reasonable period after notification of loss. Evidence of a bona fide effort must be maintained in the file. The investigation shall be deemed concluded upon the company's affirmation or denial ofliability. (b) "Notice of Claim" as applied to an insurer shall include notification given to an agent of an insurer. (c) "Settlement of claims" shall mean all activities of the company related directly or indirectly to the determination of the extent of damages due under coverages afforded by the policy. This shall include, but not be limited to, the requiring or preparing of repair estimates. (d) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday or holiday. (D) Severability If any paragraph, term, or provision of this rule be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be in and continue in full force and effect.
Life and Health Insurance Guaranty Association - disclaimer and not	OAC 3901-1-52 (C)(D)(E)	(C) Applicability. This rule applies to all insurers and agents providing, soliciting or negotiating coverage for direct, non-group life, health, annuity, and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers.

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covered form		(D) Delivery of summary document. Division (B)(2) of section 3956.18 of the Revised Code provides that no insurer shall deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract, except if division (D) of section 3956.18 of the Revised Code applies. The document also shall be available upon request by a policy or contract holder. In providing the summary document described in division (B)(2) of section 3956.18 of the Revised Code, the insurer must use the exact form of the disclaimer set forth in appendix I to this rule. (E) Policy or contract not covered by association. Division (D) of section 3956.18 of the Revised Code provides that no insurer or agent may deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code, all or a portion of which is excluded under division (B)(2)(a) of section 3956.04 of the Revised Code from coverage under Chapter 3956. of the Revised Code unless the insurer or agent, prior to or at the time of delivery gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract, or a portion of the policy or contract, is not covered by the association. In providing the document described in division (D) of section 3956.18 of the Revised Code, the insurer or agent must use the exact form set forth in appendix I to this rule.
Coordination of benefits - Purpose **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (B)	(B) Purpose The purpose of this rule is to: (1) Permit plans to include a coordination of benefits "(COB)" provision; (2) Provide the authority for the orderly transfer of information needed to pay claims promptly; (3) Eliminate duplication of benefits by permitting a plan to reduce benefits paid when, pursuant to this rule, it is not required to pay its benefits first; (4) Reduce claim payment delays; and

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		(5) Further define the "COB" statute.
Coordination of benefits - Prohibited coordination and benefit design **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (E)	(E) Prohibited coordination and benefit design (1) A contract shall not reduce benefits on the basis that: (a) Another plan exists and the covered person did not enroll in that plan; (b) A person is or could have been covered under another plan, except with respect to part B of medicare; or (c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected. (2) No contract, certificate or policy shall contain a provision that its benefits are "always excess" or "always secondary" to any other plan, except as otherwise provided in this rule. (3) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel plan provider. In most instances, "COB" does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, "COB" may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of paragraph (H) of this rule to determine the amount it should pay for the benefit. (4) No plan may use a "COB" provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under paragraph (C)(11) of this rule.
Coordination of benefits – Requirements **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (F)	(F) Requirements (1) Allowable expense (a) When plans have differing allowable expenses, the larger allowable expense shall be used for

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		the purpose of division (C) of section 3902.13 of the Revised Code. When benefits paid by a primary plan are less than the allowable expenses, the secondary plan shall pay or provide its benefits toward any remaining balance otherwise payable by the insured or the certificate holder. A secondary plan shall not be required to make a payment of an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of the larger of the expenses allowable under the provisions of the applicable policies and contracts. (b) When a plan provides benefits in the form of services, the reasonable cash value of each service shall be both an allowable expense and a benefit paid. (c) When a contract restricts "COB" to specific coverage, allowable expense shall include the expenses or services to which "COB" applies under the contract. (2) A secondary plan shall not be required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate. (3) A primary plan shall pay or provide its benefits as if the secondary plan does not exist. A plan that does not contain a coordination of benefits provision shall not take into account benefits of other plans. However, a contract holder's coverage which is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by that contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. A plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of paragraph (F)(3) of this rule, state that the complying plan is primary. (4) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. (5) When multiple contracts providing coordinated coverage are treated as a single plan under this rule, this paragraph applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be

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		responsible for the plan's compliance with this rule. (6) A secondary plan may take the benefits of another plan into account when, under this rule, it is secondary to the other plan. (7) Nothing in this rule shall be construed to prevent a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.
Coordination of benefits – Order of benefit determination **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (G)	(G) Order of benefit determination Order of benefits shall be determined by the first applicable provision set forth in this paragraph: (1) Non-dependent or dependent. The benefits of a plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, shall be determined before those of a plan which covers the person as a dependent. However, the benefits of a plan covering the person as a dependent shall be determined before the benefits of a plan covering the person as other than a dependent if the person is a medicare beneficiary, and as a result of Title XVIII of the Social Security Act and its implementing regulations: (a) Medicare is secondary to the plan covering the person as a dependent; and (b) Medicare is primary to the plan covering the person as other than a dependent (e.g. a retired employee). (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows: (a) For a dependent child whose parents are married (not separated or divorced) or are living together, whether or not they have ever been married: (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; (ii) If both parents have the same birthday, the plan which has covered the parent for a longer period of time is the primary plan;

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		(iii) If one plan does not have the rule described in paragraphs (G)(2)(a)(i) and (G)(2)(a)(ii) of this rule because that plan is not subject to the "COB" statutes, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the plan containing the rule based upon the gender of the parent shall determine the order of benefits. (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: (i) If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision. (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (G)(2)(a) of this rule shall determine the order of benefits. (iii) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the plans covering the child shall be subject to the order of benefit determination contained in paragraph (G)(2)(a) of this rule. (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows: (a) The plan covering the custodial parent; (b) The plan covering the custodial parent's spouse; (c) The plan covering the non-custodial parent; and then (d) The plan covering the non-custodial parent's spouse. (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph

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		(G)(2)(a) or (G)(2)(b) of this rule as if those individuals were the parents of the child. (3) Active employee or retired or laid-off employee. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this provision shall be ignored. This paragraph does not supersede paragraph (G)(1) of this rule. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under paragraph (G)(1) of this rule. Paragraph (G)(3) of this rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies. (4) "COBRA" or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination: (a) The plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan; (b) The continuation coverage provided pursuant to federal or state law is the secondary plan. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the order of benefits can be determined under paragraph (G)(1) of this rule. (5) Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the plan which has covered the person for the longer period of time is the primary plan and the plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision: (a) The time covered under a plan is measured from the claimant's first date of coverage under that plan, or, if that date is not readily available for a group plan, the date the claimant first became a member of the group covered by that plan shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force; (b) Two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended;

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		(c) The start of a new plan does not include: (i) A change in the amount or scope of a plan's benefits; (ii) A change in the entity that pays, provides or administers the plan's benefits; or (iii) A change from one type of plan to another, such as, from a single plan to a multiple employer plan. (6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
Coordination of benefits – Procedure for secondary and miscellaneous provisions **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (H)(I)	(H) Procedure to be followed by secondary plan to calculate benefits and pay a claim. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred per cent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. (I) Miscellaneous provisions (1) A secondary plan which provides benefits in the form of services may recover the reasonable cash value of the services from a primary plan, to the extent that benefits for the services are covered by, and have not already been paid or provided by the primary plan. Nothing in this paragraph shall be interpreted to require a plan to reimburse a covered person in cash for value of services provided by a plan that provides benefits in the form of services. (2) A plan with order of benefit determination rules which comply with this rule (complying plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with this rule (non-

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		complying plan) as follows: (a) If the complying plan is the primary plan, it shall pay or provide its benefits first; (b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. Such payment shall be the limit of the complying plan's liability; (c) If a non-complying plan does not provide the information needed by a complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. However, if the complying plan receives information within two years of payment as to the actual benefits of the non-complying plan, it shall adjust payments accordingly. (d) If a non-complying plan which paid or provided benefits as a primary plan reduces its benefits so that a claimant receives less in benefits than he would have received had the complying plan paid or provided its benefits as the secondary plan, the complying plan shall advance to, or on behalf of, the claimant an amount equal to such difference. The amount advanced, combined with other amounts previously paid by the complying plan, shall not exceed the liability of the complying plan as calculated as if the complying plan were the primary plan. In consideration of the advance, the complying plan shall be subrogated to all rights of the claimant against the non-complying plan. The advance by the complying plan shall be without prejudice to any claim it may have against the non-complying plan in the absence of subrogation. (3) A term such as "medical care" or "dental care" may be substituted for the term "health care" in describing the coverages to which the "COB" provisions of a contract apply. (4) Provisions regarding either "COB" or subrogation may be included in a health care benefits contract without compelling the inclusion or exclusion of the other in that contract. (5) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

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Unfair health claim practices **Also see the Claims Procedures section under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review Checklist for more requirements**	OAC 3901-8-11 (A)(B)(C)(D)(E)(F)(G)	(A) Authority Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge the superintendent's duties and exercise the superintendent's powers under Title XXXIX of the Revised Code. Sections 3901.20 and 3901.21 of the Revised Code, respectively, prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section. Section 3901.3813 of the Revised Code permits the superintendent to adopt rules as the superintendent considers necessary to carry out the purposes of section 3901.38 and sections 3901.381 to 3901.3812 of the Revised Code. (B) Purpose The purpose of this rule is to define certain additional unfair trade practices and to set forth minimum standards in connection with the investigation and disposition of health claims arising under policies, certificates or contracts issued pursuant to Ohio's insurance statutes, rules and regulations under Titles XVII and XXXIX of the Revised Code. Nothing herein shall be construed to create or imply a private cause of action for violation of this rule. (C) Definitions (1) "Claim" means any request submitted to a third-party payer for benefits or proceeds under a benefit plan or contract on a standardized health claim form as described in rule 3901-1-59 of the Administrative Code. (2) "Coordinated Care" means the management of health care services by a third-party payer for a beneficiary. Examples include, but are not limited to. provider selection or referral, preadmission certification, length of stay determination and second surgical opinions. (3) "Day" means calendar day. However, when the last day of a time limit stated in this rule falls

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		on a Saturday. Sunday or state or federal holiday, the time limit is extended to the next immediate following day that is not a Saturday. Sunday or holiday. (4) "Deny or Denial" means a refusal to pay any portion of a claim. The application of contractual co-pays and deductibles are not considered a denial of a claim. (5) "Documentation" includes, but is not limited to. all supporting documentation as defined in division (B)(2) of section 3901.381 of the Revised Code and any records of communications or activities, notes, work papers, claim forms, bills and explanation of benefit forms relative to a claim, including the electronic transmission of the data contained in such items. (D) General claim practices (1) A third-party payer shall notify the beneficiary and the provider of the denial of any claim. The notification shall include the specific reasons for the denial and the contract provision, condition, limitation or exclusion of the benefit plan or contract that is the basis for the denial of payment for the claim. The information must be provided in such a way that a reasonable person would understand the reasons and basis for the denial. (2) No third-party payer shall indicate to a beneficiary or provider on an electronic payment or transmittal, payment draft, check, or in any communication that the payment is "final" or a "release of claim" unless the third-party payer has paid the benefit plan or contract's limit or the provider or beneficiary has agreed to a compromise settlement. (3) When a third-party payer administers more than one benefit plan under which a beneficiary may make a claim for benefits and has been notified by the beneficiary or provider that more than one claim may be filed for benefits, the third-party payer shall establish procedures to eliminate duplicate processing procedures and to encourage concurrent processing of the claims. (4) The third-party payer shall inform the beneficiary or provider with specificity what supporting documentation is required to determine whether additional benefits would be payable. (E) Coordinated care practices

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		(1) Every third-party payer with coordinated care provisions in a benefit plan or contract shall: (a) Fully explain in the policy and certificate the procedures required for compliance with coordinated care provisions, including all penalties for failure to comply with those procedures. (b) Process claims for any services or procedures which the third-party payer has authorized pursuant to the beneficiary's or provider's compliance with coordinated care procedures subject to non-coordinated care provisions. (c) Provide the beneficiary or provider with timely written notification of the confirmation or denial of coverage pursuant to coordinated care requirements of the beneficiary's benefit plan or contract. Unless the third-party payer has determined that all claims will be paid in full or denied, the notification shall include the following statement at the top of the notice, in twelve point bold face type, before any other textual information: This is not an approval for claim payment Confirmation of (particular coordinated care provision) only We have not yet reviewed the patient's health care plan. Depending on the limitations of the health care plan, we may pay all, part, or none of the claims. (F) Reporting insurance fraud If a third-party payer reasonably believes, based upon information obtained and documented, that a beneficiary or provider has fraudulently caused or contributed to the claim as represented by a properly executed and documented claim form or billing, such information shall be presented to the fraud and enforcement division of the Ohio department of insurance within sixty days of when the fraud becomes evident. Any person making such report shall be afforded such immunity and the information submitted shall be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code. (G) File and record documentation Each third-party payer shall maintain complete documentation of every claim for a period of

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		three years. The documentation shall be sufficient to permit complete reconstruction of the third-party payer's activities and communications with respect to each claim. Documentation shall include the date of each activity or communication. All documentation shall be reproducible to paper.
Notice of older age child to age twenty-eight coverage extension **Also see the Dependent Coverage up to Age 26 section under Federal Form Review Requirements Checklist**	OAC 3901-8-13	(A) Authority This rule is promulgated pursuant to section 3901.041 of the Revised Code to implement sections 1751.14, 3923.24, and 3923.241 of the Revised Code concerning extending the age of health coverage for an employee's unmarried child to age twenty-eight. (B) Purpose The purpose of this rule is to establish requirements for notice to be given to insurance policy and certificate holders, "HIC" subscribers and public employee benefit plan members of the opportunity for enrolling eligible children up to age twenty-eight under the parent's health coverage. (C) Notice of older age child enrollment opportunity A subscriber, insured, or plan member must be given notice and information regarding the opportunity to continue coverage for or enroll an eligible child up to age twenty-eight in the parent's health coverage as described in the above statutes in the following circumstances: (1) During the employer's annual enrollment period. For plan or policy years beginning on or after July 1, 2010, if the subscriber, insured or employee has an annual period during which it is permitted to change coverage and add dependents, he or she must receive written notice of the opportunity to enroll older age children at this time. If there is no annual enrollment period, all subscribers, insureds or employees must receive written notice of the opportunity to enroll older age children within thirty days prior to the time that the coverage renews. Notice of the older age coverage opportunity must be provided to all subscribers, insureds or employees receiving coverage under policies or plans that provide dependent coverage subject to the statutes listed above. After September 23, 2010, notice may be provided pursuant to this paragraph (C)(1) of this rule or may be provided pursuant to the federal special enrollment opportunity rules described in paragraph (C)(2) of this

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		rule. (2) A special enrollment opportunity. For plan or policy years beginning on or after September 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least thirty days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. Coverage under special enrollment is effective the first day of the first plan year on or after September 23, 2010. (3) When the child reaches the limiting age. For a child currently covered by a parent's contract, policy, or plan, the notice informing the subscriber, insured, or plan member that the child is about to reach the terminating age under the health coverage must inform the subscriber, insured, or plan member about the option to request the extension of coverage. The notice must include the cost, or the steps to follow to obtain the cost information, as well as the steps to take in order to enroll for the extension of coverage. The subscriber, insured, or plan member must be given the option of enrolling the older age child for continuous coverage within the time frames established under the health contract, policy, or plan. (4) When a child experiences a change in circumstances. Notice of the opportunity to elect coverage must be provided upon the request of a subscriber, insured or plan member when an older age child experiences a change in circumstances and thereby becomes eligible for extended coverage. A change in circumstances can include moving back to Ohio or the child losing employer-sponsored coverage. Upon receiving the request from the subscriber, insured or plan member, the eligible older age dependent must be offered the opportunity to enroll within thirty days. Coverage must be effective within thirty days of the health insuring corporation, insurer, plan or administrator receiving both the notice of the election and the premium payment