

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
<b>Basic Health Care Services</b>	ORC 1751.01 (A)(1)	<p>As used in this chapter:</p> <p>(A)(1) "Basic health care services" means the following services when medically necessary:</p> <p>(a) Physician's services, except when such services are supplemental under division (B) of this section;</p> <p>(b) Inpatient hospital services;</p> <p>(c) Outpatient medical services;</p> <p>(d) Emergency health services;</p> <p>(e) Urgent care services;</p> <p>(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;</p> <p>(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;</p> <p>(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;</p> <p>(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.</p> <p>"Basic health care services" does not include experimental procedures.</p> <p>Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it</p>

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		offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.
<b>Biologically Based Mental Illness</b>  <u>Also see Mental Health and substance Use Disorder Parity section under the Federal Form Review Requirements Checklist</u>	ORC 1751.01 (A)(2)	(A)(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.
<b>Supplemental Health Care Services</b>  <u>Also see Essential Health Benefits Form Review Checklist</u>	ORC 1751.01 (B)	(B) (1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes: <ul style="list-style-type: none"> <li>(a) Services of facilities for intermediate or long-term care, or both;</li> <li>(b) Dental care services;</li> <li>(c) Vision care and optometric services including lenses and frames;</li> </ul>

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		<p>(d) Podiatric care or foot care services;</p> <p>(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;</p> <p>(f) Short-term outpatient evaluative and crisis-intervention mental health services;</p> <p>(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;</p> <p>(h) Home health services;</p> <p>(i) Prescription drug services;</p> <p>(j) Nursing services;</p> <p>(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;</p> <p>(l) Physical therapy services;</p> <p>(m) Chiropractic services;</p> <p>(n) Any other category of services approved by the superintendent of insurance.</p> <p>(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.</p>

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<b>Specialty Health Care Services</b>	ORC 1751.01 (C)	(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.
<b>Definitions</b>	ORC 1751.01 (D) – (CC)	<p>(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.</p> <p>(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.</p> <p>(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.</p> <p>(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.</p> <p>(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.</p> <p>(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.</p> <p>(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.</p>

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		<p>(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.</p> <p>(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.</p> <p>(M) "Health care services" means basic, supplemental, and specialty health care services.</p> <p>(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.</p> <p>(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.</p> <p>"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of</p>

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		<p>developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.</p> <p>(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.</p> <p>(Q) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.</p> <p>(R)</p> <p>"Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.</p> <p>(S) (1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.</p> <p>(2) No health insuring corporation may offer an open panel plan, unless the health</p>

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		<p>insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.</p> <p>(T) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:</p> <p>(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;</p> <p>(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;</p> <p>(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.</p> <p>(U) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.</p> <p>(V) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.</p> <p>(W) "Premium rate" means any set fee regularly paid by a subscriber to a health</p>

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		<p>insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.</p> <p>(X) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.</p> <p>(Y) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.</p> <p>(Z) "Provider sponsored organization" means a corporation, as defined in division (H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination</p>

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		<p>of the physicians and hospitals described in this division.</p> <p>(AA) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.</p> <p>(BB) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.</p> <p>(CC) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.</p>
<b>Application of insurance laws – solicitation</b>	ORC 1751.08 (C)	(C) Solicitation of enrollees by a health insuring corporation holding a certificate of authority under this chapter, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.
<b>Unfair and deceptive acts - use of name</b>	ORC 1751.20 (C)	(C) All solicitation documents, advertisements, evidences of coverage, and enrollee identification cards used by a health insuring corporation shall contain the health insuring corporation's name. The use of a trade name, an insurance group designation, the name of a parent company, the name of a division of an affiliated insurance company, a service mark, a slogan, a symbol, or other device, without the name of the health insuring corporation as stated in its articles of incorporation, shall not satisfy this requirement if the usage would have the capacity and tendency to mislead or deceive persons as to the true identity of the health insuring corporation.

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<b>Unfair and deceptive acts – terms and DBAs</b>	ORC 1751.20 (E)	(E) A health insuring corporation that provides basic health care services may use the phrase “health maintenance organization” or the abbreviation “HMO” in its marketing name, advertising, solicitation documents, or marketing literature, or in reference to the phrase “doing business as” or the abbreviation “DBA.”
<b>Solicitation Document – required content</b>	ORC 1751.31 (B)	B) The solicitation document shall contain all information necessary to enable a consumer to make an informed choice as to whether or not to enroll in the health insuring corporation. The information shall include a specific description of the health care services to be available and the approximate number and type of full-time equivalent medical practitioners. The information shall be presented in the solicitation document in a manner that is clear, concise, and intelligible to prospective applicants in the proposed service area.
<b>Solicitation Requirements for Medicare, Medicaid and federal employees</b>	ORC 1751.31 (D)	<p>(D) Notwithstanding division (A) of this section, a health insuring corporation may use a solicitation document that the corporation uses in connection with policies for medicare beneficiaries pursuant to a medicare risk contract or medicare cost contract, or for policies for beneficiaries of the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies for medicare recipients, or for policies for beneficiaries of any other federal health care program regulated by a federal regulatory body, or for policies for beneficiaries of contracts covering officers or employees of the state entered into by the department of administrative services, if both of the following apply:</p> <p>(1) The solicitation document has been approved by the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services.</p> <p>(2) The solicitation document is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services.</p>

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<b>Solicitation Document – right to cancel</b>	ORC 1751.31 (F)	(F) Any person obligated for any part of a premium rate in connection with an enrollment agreement, in addition to any right otherwise available to revoke an offer, may cancel such agreement within seventy-two hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of the cancellation is given to the health insuring corporation or its agents or other representatives. A notice of cancellation mailed to the health insuring corporation shall be considered to have been filed on its postmark date.
<b>Restriction on choice of providers</b>  <b><u>Also see Provider – Scope of Practice section under the Federal Form Review Requirements Checklist</u></b>	ORC 1751.51 (B)	<p>If a health care plan of a health insuring corporation covers health care services that may be legally performed by a class of providers referred to in section <a href="#">3923.23</a> or <a href="#">3923.231</a> of the Revised Code but would restrict an enrollee’s ability to receive these health care services from members of that class in any manner that differs from an enrollee’s ability under the health care plan to receive these health care services from any other class of providers that may legally perform these health care services, then the health insuring corporation shall do both of the following:</p> <p>(B) Set forth, within any solicitation document pertaining to the health care plan and within any solicitation materials pertaining to the health care plan that the health insuring corporation provides to any employer or any employee benefit fund, under a heading that reads “Restrictions on Choice of Providers,” a clear, concise, and complete statement of the restriction, such statement being subject to prior approval by the superintendent of insurance in accordance with the same form and content requirements that are specified in section <a href="#">1751.11</a> of the Revised Code with regard to evidence of coverage.</p>
<b>Information available to the employer - <u>SMALL EMPLOYER PLANS</u></b>	ORC 3924.033 (A)(B)	<p>(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:</p> <p>(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;</p> <p>(2) The provisions of the plan relating to renewability of coverage;</p>

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		<p>(3) The provisions of the plan relating to any pre-existing condition exclusion;</p> <p>(4) The benefits and premiums available under all health benefit plans for which the employer is qualified.</p> <p>(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.</p>
<p><b>Coordination of benefits – required language</b></p> <p><b>See definitions in OAC 3901-8-01 (C)</b></p>	OAC 3901-8-01 (D)(1)	<p>(1) The following language shall be included as a separate and distinct paragraph on the first page in at least one solicitation, marketing, advertising or enrollment document which shall be provided to potential subscribers of a plan subject to this rule and shall be printed in twelve point type:</p> <p>“WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.”</p>
<p><b>Form identification</b></p> <p><b>See definitions in OAC 3901-8-07 (C)</b></p>	OAC 3901-8-07 (B)(3)	<p>(3) Advertisements that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.</p>
<p><b>Clearly identify product as an insurance policy</b></p> <p><b>See definitions in</b></p>	OAC 3901-8-07 (E)(6)	<p>(6) An insurer shall clearly identify its sickness and accident policy as an insurance policy. A policy trade name shall be followed by the words “insurance policy” or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health insuring corporations, prepaid health plans and other direct service organizations) is being offered.</p>

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<u>OAC 3901-8-07 (C)</u>		
<b>Advertisement of benefits payable</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	OAC 3901-8-07 (F)(1)(f)	(f) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless such statements of such monthly or weekly benefit amounts are preceded immediately by equally prominent statements of the benefit payable on a daily basis; for example, the following statement is acceptable: "\$ 33.33 a day (\$1, 000.00 a month)." When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.
<b>Exceptions, reductions and limitations of benefits - Invitation to contract</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	OAC 3901-8-07 (F)(2)(a)	(a) When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.
<b>Waiting periods between effective dates - Invitation to contract</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	OAC 3901-8-07 (F)(2)(b)	(b) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

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<p><b>Pre-existing conditions: definition and use - <u>Invitation to contract</u></b></p> <p><b>See definitions in <u>OAC 3901-8-07 (C)</u></b></p>	<p>OAC 3901-8-07 (F)(3)(a)</p>	<p>(a) An advertisement which is subject to the requirements of paragraph (F)(2) of this rule shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term “pre-existing condition” without an appropriate definition or description is not permissible.</p>
<p><b>Pre-existing conditions: disclosure - <u>Invitation to contract</u></b></p> <p><b>See definitions in <u>OAC 3901-8-07 (C)</u></b></p>	<p>OAC 3901-8-07 (F)(3)(b)</p>	<p>(b) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant’s physical condition or medical history will not affect issuance of the policy or the payment of a claim thereunder. This prohibits the use of the phrase “no medical examination required” and phrases of similar import, but does not prohibit explaining “automatic issue.” If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.</p>
<p><b>Pre-existing conditions: requirements for application with advertising</b></p> <p><b>See definitions in <u>OAC 3901-8-07 (C)</u></b></p>	<p>OAC 3901-8-07 (F)(3)(c)</p>	<p>(c) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct-response insurance product, such application form shall contain a question which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant’s signature. For example, such an application form shall contain a question substantially as follows: “Do you understand that this policy will not pay benefits during the first <u>  </u> year(s) after the issue date for a disease or physical conditions which you now have or have had in the past?” <u>  </u> YES. Or substantially the following statement: “I understand that the policy applied for will not pay benefits for any loss incurred during the first <u>  </u> year(s) after the issue date on account of disease or physical conditions which I now have or have had in the past.”</p>
<p><b>Disclosure of policy provisions - <u>Invitation to contract</u></b></p> <p><b>See definitions in <u>OAC 3901-8-07 (G)</u></b></p>	<p>OAC 3901-8-07 (G)</p>	<p>(G) When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons in a manner which shall not minimize or render obscure the qualifying conditions.</p>

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<b>Required disclosure</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	OAC 3901-8-07 (H)(2)(c)	(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
<b>Testimonials or endorsements by third parties - financial interest, compensation</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	<a href="#">OAC 3901-8-07 (I)(2)</a>	(2) If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This disclosure shall be in a type style and size at least equal to that used for the person's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence. This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation.
<b>Testimonials or endorsements by third parties - proprietary relationship</b>  <u>See definitions in OAC 3901-8-07 (C)</u>	OAC 3901-8-07 (I)(3)	(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls or holds any policy-making position in the entity making the endorsement or testimonial, that fact must be disclosed.

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<p><b>Use of statistics – pertinent facts, data for a different policy</b></p> <p><u>See definitions in OAC 3901-8-07 (C)</u></p>	OAC 3901-8-07 (J)(1)	<p>(1) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state. Where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised.</p>
<p><b>Use of statistics – identity of the source</b></p> <p><u>See definitions in OAC 3901-8-07 (C)</u></p>	OAC 3901-8-07 (J)(3)	<p>(3) The source of any statistics used in an advertisement shall be identified in such advertisement.</p>
<p><b>Identification of plan or premium - Invitation to contract</b></p> <p><u>See definitions in OAC 3901-8-07 (C)</u></p>	OAC 3901-8-07 (K)(1)	<p>(1) When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.</p>
<p><b>Identification of number of policies - Invitation to contract</b></p> <p><u>See definitions in OAC 3901-8-07 (C)</u></p>	OAC 3901-8-07 (K)(2)	<p>(2) When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.</p>
<p><b>Identity of the Insurer</b></p> <p><u>See definitions in OAC 3901-8-07 (C)</u></p>	OAC 3901-8-07 (N)(1)	<p>(1) The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have</p>

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
		the capacity and tendency to mislead or deceive as to the true identity of the insurer.
<b>Group or quasi-group implications - <u>Invitation to contract</u></b>  <b>See definitions in <u>OAC 3901-8-07 (C)</u></b>	OAC 3901-8-07 (O)(2)	(2) An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when that is not the fact.
<b>Enrollment period response date</b>  <b>See definitions in <u>OAC 3901-8-07 (C)</u></b>	OAC 3901-8-07 (P)(1)(b)	(b) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, website and other internet displays or communications, other forms of electronic communications, billboards and similar displays, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Revised Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.