

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
Basic Health Care Services	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 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.</p>

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<p>Biologically Based Mental Illness</p> <p><u>Also see Mental Health and Substance Use Disorder Parity section under the Federal Form Review Requirements Checklist</u></p>	ORC 1751.01 (A)(2)	<p>(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.</p>
<p>Supplemental Health Care Services</p> <p><u>Also see Essential Health Benefits Form Review Checklist</u></p>	ORC 1751.01 (B)	<p>(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:</p> <ul style="list-style-type: none"> (a) Services of facilities for intermediate or long-term care, or both; (b) Dental care services; (c) Vision care and optometric services including lenses and frames; (d) Podiatric care or foot care services; (e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses; (f) Short-term outpatient evaluative and crisis-intervention mental health services; (g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; (h) Home health services; (i) Prescription drug services; (j) Nursing services; (k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

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		<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>
Specialty Health Care Services	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.
Definitions	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</p>

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		<p>health insuring corporation.</p> <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 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>

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		<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 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</p>

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		<p>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 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</p>

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		<p>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 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>
Powers upon obtaining COA - Enrollment	ORC 1751.06 (A)	<p>Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following:</p> <p>A) Enroll individuals and their dependents in either of the following circumstances:</p> <p>(1) The individual resides or lives in the approved service area.</p> <p>(2) The individual's place of employment is located in the approved service area.</p>
Powers upon obtaining COA – Affiliation period	ORC 1751.06 (G)	<p>Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following:</p> <p>(G) In the employer group market, impose an affiliation period of not more than sixty days, or for late enrollees an affiliation period of not more than ninety days, which period begins on the individual's date of enrollment and runs concurrently with any waiting period imposed under the coverage. For purposes of this division, "affiliation period" means a period of time which, under the terms of the</p>

SMALL GROUP HIC EOC Filing Guidance – FORM REVIEW REQUIREMENTS

TOIS: HOrg02G.004F Small Group Health Organizations – Health Maintenance (HMO) – Small Group ONLY

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		coverage offered, must expire before the coverage becomes effective. No health care services or benefits need to be provided during an affiliation period, and no periodic prepayments can be charged for any coverage during that period.
Powers upon obtaining COA – Network requirements	ORC 1751.06 (H)	Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following: (H) If a health insuring corporation offers coverage in the small employer group market through a network plan, limit or deny the coverage in accordance with section 3924.031 of the Revised Code;
Powers upon obtaining COA – contributions, participation	ORC 1751.06 (J)	Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following: (J) Establish employer contribution rules or group participation rules for the offering of coverage in connection with a group contract in the small employer group market, as provided in division (E)(1) of section 3924.03 of the Revised Code.
ID Card Requirements	ORC 1751.11 (B)	(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one toll-free telephone number that provides the subscriber with access, to information on a twenty-four-hours-per-day, seven-days-per-week basis, as to how health care services may be obtained. The identification card or document shall also list at least one toll-free number that, during normal business hours, provides the subscriber with access to information on the coverage available under the subscriber's health care plan and information on the health care plan's internal and external review processes.
EOC Requirements <u>Also see Chapter 3922 External Review Checklist</u>	ORC 1751.11 (D)	(D) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used: (1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive; (2) Unless it contains a clear, concise, and complete statement of the following: (a) The health care services and insurance or other benefits, if any, to which an enrollee is entitled under the health care plan; (b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments and deductibles; (c) An enrollee's personal financial obligation for noncovered services;

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		<p>(d) Where and in what manner general information and information as to how health care services may be obtained is available, including a toll-free telephone number;</p> <p>(e) The premium rate with respect to individual and conversion contracts, and relevant copayment and deductible provisions with respect to all contracts. The statement of the premium rate, however, may be contained in a separate insert.</p> <p>(f) The method utilized by the health insuring corporation for resolving enrollee complaints;</p> <p>(g) The utilization review, internal review, and external review procedures established under sections 1751.77 to 1751.83 and Chapter 3922 of the Revised Code.</p> <p>(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the group policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following:</p> <p>(a) The enrollee's discharge from the hospital;</p> <p>(b) The determination by the enrollee's attending physician that inpatient care is no longer medically indicated for the enrollee; however, nothing in division (D)(3)(b) of this section precludes a health insuring corporation from engaging in utilization review as described in the evidence of coverage.</p> <p>(c) The enrollee's reaching the limit for contractual benefits;</p> <p>(d) The effective date of any new coverage.</p> <p>(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any guaranty fund, and that in the event of the health insuring corporation's insolvency, an enrollee is protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered;</p> <p>(5) Unless it contains a provision that states, in substance, that in the event of the insolvency of the health insuring corporation, an enrollee may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to the health insuring corporation, whether or not the health insuring corporation authorized the use of the provider or health care facility.</p>

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EOC Requirements for Medicare, Medicaid and federal employees	ORC 1751.11 (E)	<p>(E) Notwithstanding divisions (C) and (D) of this section, a health insuring corporation may use an evidence of coverage that provides for the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage that provides for the coverage of medicaid recipients, or an evidence of coverage that provides for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or an evidence of coverage that provides for 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, if both of the following apply:</p> <p>(1) The evidence of coverage 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 evidence of coverage 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>
Standardized prescription identification card information	ORC 1751.111 (A)(B)(C)	<p>(A)(1) This section applies to both of the following:</p> <p>(a) A health insuring corporation that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;</p> <p>(b) A person or entity that a health insuring corporation contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.</p> <p>(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims in connection with any of the following:</p> <p>(a) Coverage provided under the medicare advantage program operated pursuant to Part C of Title XVIII of the "Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended.</p>

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		<p>(b) Coverage provided under medicaid.</p> <p>(c) Coverage provided under an employer’s self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.</p> <p>(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.</p> <p>(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council’s or successor organization’s pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.</p> <p>(2) If the health insuring corporation or the person under contract with the corporation to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:</p> <p>(a) The health insuring corporation’s name;</p> <p>(b) The subscriber’s name, group number, and identification number;</p> <p>(c) A telephone number to inquire about pharmacy-related issues;</p> <p>(d) The issuer’s international identification number, labeled as “ANSI BIN” or “RxBIN”;</p> <p>(e) The processor’s control number, labeled as “RxPCN”;</p> <p>(f) The subscriber’s pharmacy benefits group number if different from the subscriber’s medical group number, labeled as “RxGrp.”</p> <p>(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation “Rx” is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer’s international identification number or the processor’s control number is different for medical and pharmacy claims.</p>

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<p>Restrictions on Copayments, Lifetime Maximums, Deductibles and Higher Deductibles</p> <p><u>Also see Lifetime, Annual, Cost Share and Deductible Limits sections under the Federal Form Review Requirements Checklist and the Essential Health Benefits Form Review Checklist</u></p>	<p>ORC 1751.12 (D)(E) (F)(G)</p>	<p>(D)</p> <p>(1) Copayments, cost sharing, and deductibles must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.</p> <p>(2) A health insuring corporation, in order to ensure that copayments, cost sharing, and deductibles are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees shall impose copayment charges, cost sharing, and deductible charges that annually do not exceed forty per cent of the total annual cost to the health insuring corporation of providing all covered health care services when applied to a standard population expected to be covered under the filed product in question. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. This requirement shall be demonstrated by an actuary who is a member of the American academy of actuaries and qualified to provide such certifications as described in the United States qualification standards promulgated by the American academy of actuaries pursuant to the code of professional conduct.</p> <p>(3)</p> <p>For purposes of division (D) of this section, all of the following apply:</p> <p>(a) Copayments imposed by health insuring corporations in connection with a high deductible health plan that is linked to a health savings account are reasonable and are not a barrier to the necessary utilization of services by enrollees.</p> <p>(b) Division (D)(2) of this section does not apply to a high deductible health plan that is linked to a health savings account.</p> <p>(c) Catastrophic-only plans, as defined under the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18022 and any related regulations, are not subject to the limits prescribed in division (D) of this section, provided that such plans meet all applicable minimum federal requirements.</p>

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		<p>(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.</p> <p>(F)</p> <p>The superintendent may adopt rules allowing different copayment, cost sharing, and deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account;</p> <p>(G) A health insuring corporation may impose higher copayment, cost sharing, and deductible charges under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.</p>
Provider Contracts – required services of a non-contracted provider	ORC 1751.13 (A)(2)	<p>(A)(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.</p>
Continuing coverage for dependent children <u>Also see the Dependent Coverage up to Age 26 section under the Federal</u>	ORC 1751.14	<p>(A) Notwithstanding section 3901.71 of the Revised Code, any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance both of the following:</p> <p>(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, contract, or agreement, upon the request of the subscriber, the health insuring corporation</p>

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		<p>(3) Require an employer to offer health insurance coverage to the dependents of any employee.</p> <p>(D) This section does not apply to any health insuring corporation policy, contract, or agreement offering only supplemental health care services or specialty health care services.</p> <p>(E) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following:</p> <p>(1) A public employee benefit plan;</p> <p>(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.</p>
<p>Dependent children outside of the service area</p> <p><u>Also see the Dependent Coverage up to Age 26 section under the Federal Form Review Requirements Checklist</u></p>	ORC 1751.141	A health insuring corporation shall provide coverage, in accordance with the terms of the contract, for a subscriber's dependent children living outside the health insuring corporation's approved service area if a court order requires the subscriber to provide health care coverage to the dependent children.
<p>Option for conversion</p>	ORC 1751.16 (A)(B)(C)(E)	Suspended effective 1/1/2014 through 1/1/2018 (Ohio Senate Bill 9, 130 th GA)
<p>Restrictions on cancelling or failing to renew coverage</p> <p><u>Also see the Guaranteed Renewable, Internal Appeals and External</u></p>	ORC 1751.18 (B)(C)(D)	<p>(B) A health insuring corporation may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the enrollee.</p> <p>(C) An enrollee may appeal any action or decision of a health insuring corporation taken pursuant to section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191 , 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the enrollee may submit a</p>

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<p><u>Review sections under the Federal Form Review Requirements Checklist</u></p>		<p>written complaint to the health insuring corporation pursuant to section 1751.19 of the Revised Code. The enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.</p> <p>(D) As used in this section, "health status-related factor" means any of the following:</p> <ul style="list-style-type: none"> (1) Health status; (2) Medical condition, including both physical and mental illnesses; (3) Claims experience; (4) Receipt of health care; (5) Medical history; (6) Genetic information; (7) Evidence of insurability, including conditions arising out of acts of domestic violence; (8) Disability.
<p>Complaint system</p>	<p>ORC 1751.19 (A)(D)</p>	<p>(A) A health insuring corporation shall establish and maintain a complaint system that has been approved by the superintendent of insurance to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by subscribers or enrollees concerning any matter relating to services provided, directly or indirectly, by the health insuring corporation, including, but not limited to, complaints regarding cancellations or nonrenewals of coverage. Complaints regarding a health insuring corporation's decision to deny, reduce, or terminate coverage for health care services are subject to section 1751.83 of the Revised Code.</p> <p>(D) A health insuring corporation shall establish and maintain a procedure to accept complaints over the telephone or in person. These complaints are not subject to the reporting requirement under division (C) of section 1751.32 of the Revised Code.</p>
<p>Unfair and deceptive</p>	<p>ORC 1751.20 (C)</p>	<p>(C) All solicitation documents, advertisements, evidences of coverage, and enrollee identification cards</p>

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acts - use of name		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.
Unfair and deceptive acts – terms and DBAs	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."
Restriction on choice of providers <u>Also see Provider – Scope of Practice section under the Federal Form Review Requirements Checklist</u>	ORC 1751.51 (A)	<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 3923.23 or 3923.231 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>(A) Set forth, within any evidence of coverage pertaining to the health care plan, under a heading that reads "Restrictions on Choice of Providers," a clear, concise, and complete statement of the restriction that conforms to the requirements of section 1751.11 of the Revised Code;</p>
Continuing coverage after termination of employment – definitions, requirement and specifications	ORC 1751.53 (A)(B)(C)	<p>(A) As used in this section:</p> <p>(1) "Group contract" means a group health insuring corporation contract covering employees that meets either of the following conditions:</p> <p>(a) The contract was issued by an entity that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1738 or 1742 of the Revised Code, and covers an employee at the time the employee's employment is terminated.</p> <p>(b) The contract is delivered, issued for delivery, or renewed in this state after June 4, 1997, and covers an employee at the time the employee's employment is terminated.</p>

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		<p>(2) "Eligible employee" means an employee to whom all of the following apply:</p> <p>(a) The employee has been continuously covered under a group contract or under the contract and any prior similar group coverage replaced by the contract, during the entire three-month period preceding the termination of the employee's employment.</p> <p>(b) [The employee did not voluntarily terminate the employee's employment and the termination of employment is not a result of any gross misconduct on the part of the employee] .</p> <p>(c) The employee is not, and does not become, covered by or eligible for coverage by medicare.</p> <p>(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the employee was not covered immediately prior to the termination of employment. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.</p> <p>(B) A group contract shall provide that any eligible employee may continue the coverage under the contract, for the employee and the employee's eligible dependents, for a period of twelve months after the date that the group coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage issued to employees under the contract shall include a notice of the employee's privilege of continuation.</p> <p>(C) All of the following apply to the continuation of group coverage required under division (B) of this section:</p> <p>(1) Continuation need not include any supplemental health care services benefits or specialty health care services benefits provided by the group contract.</p> <p>(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section.</p> <p>(3) The employee shall file a written election of continuation with the employer and pay the employer</p>

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		<p>the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates:</p> <p>(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate;</p> <p>(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to this date;</p> <p>(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.</p> <p>(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment.</p> <p>(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs:</p> <p>(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section;</p> <p>(b) A period of twelve months expires after the date that the employee's coverage under the group contract would otherwise have terminated because of the termination of employment;</p> <p>(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;</p> <p>(d) The group contract is terminated, or the employer terminates participation under the contract, unless the employer replaces the coverage by similar coverage under another contract or other group health arrangement. If the employer replaces the contract with similar group health coverage, all of the following apply:</p> <p>(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated.</p>

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		<p>(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the contract replaced reduced by any benefits payable under the contract replaced.</p> <p>(iii) The contract replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.</p>
<p>Continuing coverage when reservist is called or ordered to active duty - definitions, requirement and specifications</p>	<p>ORC 1751.54 (A)(B) (C)(D)(E)(F)(G)</p>	<p>(A) As used in this section:</p> <p>(1) "Eligible person" means any person who, at the time a reservist is called or ordered to active duty, is covered under a group contract and is either of the following:</p> <p>(a) An employee who is a reservist called or ordered to active duty;</p> <p>(b) The spouse or a dependent child of an employee described in division (A)(1)(a) of this section.</p> <p>(2) "Group contract" includes any group health insuring corporation contract that satisfies all of the following:</p> <p>(a) The contract is delivered, issued for delivery, or renewed in this state on or after June 4, 1997.</p> <p>(b) The contract covers employees for health care services, including basic health care services.</p> <p>(c) The contract is in effect and covers an eligible person at the time a reservist is called or ordered to active duty.</p> <p>(3) "Reservist" means a member of a reserve component of the armed forces of the United States. "Reservist" includes a member of the Ohio national guard.</p> <p>(B) Every group contract shall provide that any eligible person may continue the coverage under the contract for a period of eighteen months after the date on which the coverage would otherwise terminate because the reservist is called or ordered to active duty.</p> <p>(C)</p> <p>(1) An eligible person may extend the eighteen-month period of continuation of coverage to a thirty-six-month period of continuation of coverage, if any of the following occurs during the eighteen-month</p>

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		<p>period:</p> <p>(a) The death of the reservist;</p> <p>(b) The divorce or separation of a reservist from the reservist's spouse;</p> <p>(c) The cessation of dependency of a child pursuant to the terms of the contract.</p> <p>(2) The thirty-six-month period of continuation of coverage is deemed to begin on the date on which the coverage would otherwise terminate because the reservist is called or ordered to active duty.</p> <p>(3) The employer may begin the thirty-six-month period on the date of any occurrence described in division (C)(1) of this section.</p> <p>(D) All of the following apply to any continuation of coverage, or the extension of any continuation of coverage, provided under division (B) or (C) of this section:</p> <p>(1) The continuation of coverage shall provide the same benefits as those provided to any similarly situated eligible person who is covered under the same group contract and an employee who has not been called or ordered to active duty.</p> <p>(2) An employer shall notify each employee of the right of continuation of coverage at the time of employment. At the time the reservist is called or ordered to active duty, the employer shall notify each eligible person of the requirements for the continuation of coverage.</p> <p>(3) Each certificate of coverage issued by a health insuring corporation to an employee under the group contract shall include a notice of the eligible person's right of continuation of coverage.</p> <p>(4) An eligible person shall file a written election of continuation of coverage with the employer and pay the employer the first contribution required under division (D)(5) of this section. The written election and payment must be received by the employer no later than thirty-one days after the date on which the eligible person's coverage would otherwise terminate. If the employer notifies the eligible person of the right of continuation of coverage after the date on which the eligible person's coverage would otherwise terminate, the written election and payment must be received by the employer no later than thirty-one days after the date of the notification.</p> <p>(5)</p> <p>(a) Except as provided in division (D)(5)(b) or (c) of this section, the eligible person shall pay to the</p>

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		<p>employer, on a monthly basis and in advance, the amount of contribution required by the employer. The amount shall not exceed one hundred two per cent of the group rate for the coverage being continued under the group contract on the due date of each payment.</p> <p>(b) The employer may pay a portion or all of the eligible person's contribution.</p> <p>(c) A reservist called or ordered to active duty for less than thirty-one days shall not be required to pay more than the eligible person's contribution, if any, for the coverage.</p> <p>(E) The eligible person's right to any continuation of coverage, or the extension of any continuation of coverage, provided under division (B) or (C) of this section ceases on the date on which any of the following occurs:</p> <p>(1) The eligible person, whether as an employee or otherwise, becomes covered by another group contract or other group health plan or arrangement that does not contain any exclusion or limitation with respect to any preexisting condition of that eligible person. For purposes of division (E)(1) of this section, a group contract or other group health plan or arrangement does not include the civilian health and medical program of the uniformed services as defined in Public Law 99-661 , 100 Stat. 3898 (1986), 10 U.S.C.A. 1072.</p> <p>(2) The period of either eighteen months provided under division (B) of this section or thirty-six months provided under division (C) of this section expires.</p> <p>(3) The eligible person fails to make a timely payment of a required contribution, in which case the coverage ceases at the end of the period of coverage for which contributions were made.</p> <p>(4) The group contract, or participation under the group contract, is terminated, unless the employer, in accordance with division (F) of this section, replaces the coverage with similar coverage under another group contract or other group health plan or arrangement.</p> <p>(F) If the employer replaces the group contract with similar coverage as described in division (E)(4) of this section, both of the following apply:</p> <p>(1) The eligible person is covered under the replacement coverage for the balance of the period that the person would have remained covered under the terminated coverage if it had not been terminated.</p> <p>(2) The level of benefits under the replacement coverage is the same as the level of benefits provided to any similarly situated eligible person who is covered under the group contract and an employee who</p>

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		<p>has not been called or ordered to active duty.</p> <p>(G) Upon the reservist's release from active duty and the reservist's return to employment for the employer by whom the reservist was employed at the time the reservist was called or ordered to active duty, both of the following apply:</p> <p>(1) Every eligible person is entitled, without any waiting period, to coverage under the employer's group contract that is in effect at the time of the reservist's return to employment.</p> <p>(2) Every eligible person is entitled to all benefits under the group contract described in division (G)(1) of this section from the date of the original coverage under the contract.</p>
Effect of workers compensation coverage	ORC 1751.55	<p>A health insuring corporation policy, contract, or agreement shall not be construed to exclude illness or injury upon the ground that the subscriber might have elected to have such illness or injury covered by workers' compensation under Chapter 4123 of the Revised Code unless the policy, contract, or agreement clearly excludes work or occupational related illness or injury, or the policy, contract, or agreement, or a separate writing signed by the subscriber, informs the subscriber that such coverage is excluded and may be available to the subscriber under workers' compensation as the sole proprietor of a business, a member of a partnership, or an officer of a family farm corporation.</p>
Coverage of adopted children	ORC 1751.59	<p>No individual or group health insuring corporation policy, contract, or agreement that makes family coverage available may be delivered, issued for delivery, or renewed in this state, unless the policy, contract, or agreement covers adopted children of the subscriber on the same basis as other dependents.</p> <p>The coverage required by this section is subject to the requirements and restrictions set forth in section 3924.51 of the Revised Code.</p>
Provider or facility limited to seek compensation for covered services solely from HIC	ORC 1751.60 (A)(B)(C)(D)(F)	<p>(A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.</p> <p>(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage.</p>

SMALL GROUP HIC EOC Filing Guidance – FORM REVIEW REQUIREMENTS

TOIS: HOrg02G.004F Small Group Health Organizations – Health Maintenance (HMO) – Small Group ONLY

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		<p>(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles.</p> <p>(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services.</p> <p>(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.</p>
Coverage for newly born child	ORC 1751.61	<p>(A) Each individual or group evidence of coverage that is delivered, issued for delivery, or renewed by a health insuring corporation in this state, and that makes coverage available for family members of a subscriber, also shall provide that coverage applicable to children is payable from the moment of birth with respect to a newly born child of the subscriber or subscriber's spouse.</p> <p>(B) Coverage for a newly born child is effective for a period of thirty-one days from the date of birth.</p> <p>(C) To continue coverage for a newly born child beyond the thirty-one day period described in division (B) of this section, the subscriber shall notify the health insuring corporation within that period.</p> <p>(D) If payment of a specific premium rate is required to provide coverage under this section for an additional child, the evidence of coverage may require the subscriber to make this payment to the health insuring corporation within the thirty-one day period described in division (B) of this section in order to continue the coverage beyond that period.</p>
Screening mammography and cytologic screening benefits <u>Also see Preventive Services section under the Federal Form Review Requirements</u>	ORC 1751.62	<p>(A) As used in this section:</p> <p>(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.</p>

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<u>Checklist</u>		<p>“Screening mammography” does not include diagnostic mammography.</p> <p>(2) “Medicare reimbursement rate” means the reimbursement rate paid in Ohio under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.</p> <p>(B) Every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:</p> <p>(1) Screening mammography to detect the presence of breast cancer in adult women;</p> <p>(2) Cytologic screening for the presence of cervical cancer.</p> <p>(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:</p> <p>(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;</p> <p>(2) If a woman is at least forty years of age but under fifty years of age, either of the following:</p> <p>(a) One screening mammography every two years;</p> <p>(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.</p> <p>(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.</p> <p>(D)(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio</p>

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		<p>paid by medicare in this state for that component.</p> <p>(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.</p> <p>(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.</p> <p>(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.</p> <p>(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.</p> <p>(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.</p>
Prescription drug limitations and exclusions	ORC 1751.66 (A)(B)(C)	(A) No individual or group health insuring corporation policy, contract, or agreement that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets the criteria specified in division (B) of this section.

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		<p>(B) Medical literature may be accepted for purposes of division (A) of this section only if all of the following apply:</p> <p>(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;</p> <p>(2) No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;</p> <p>(3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to Section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 (x)(t)(2)(B), as amended, as accepted peer-reviewed medical literature.</p> <p>(C) Coverage of a drug required by division (A) of this section includes medically necessary services associated with the administration of the drug.</p>
<p>Coverage for inpatient care and follow-up for mother and her newborn</p> <p><u>Also see Newborns' and Mothers' coverage section under the Federal Form Review Requirements Checklist</u></p>	<p>ORC 1751.67 (A)(B)</p>	<p>(A) Each individual or group health insuring corporation policy, contract, or agreement delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:</p> <p>(1) The policy, contract, or agreement shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.</p> <p>(2) The policy, contract, or agreement shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.</p>

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		<p>When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the provider responsible for discharging the mother or newborn.</p> <p>(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.</p>
<p>Utilization, Internal and External Review – application of provisions</p> <p><u>See definitions in ORC 1751.77</u></p> <p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>	<p>ORC 1751.78</p>	<p>(A)(1) Sections 1751.77 to 1751.87 and Chapter 3922 of the Revised Code apply to any health insuring corporation that provides or performs utilization review services in connection with its policies, contracts, and agreements covering basic health care services and to any designee of the health insuring corporation, or to any utilization review organization that performs utilization review functions on behalf of the health insuring corporation in connection with policies, contracts, or agreements of the health insuring corporation covering basic health care services.</p> <p>(2) Nothing in sections 1751.77 to 1751.82 or section 1751.823 of the Revised Code shall be construed to require a health insuring corporation to provide or perform utilization review services in connection with health care services provided under a policy, plan, or agreement of supplemental health care services or specialty health care services.</p> <p>(B)(1) Each health insuring corporation shall be responsible for monitoring all utilization review and internal review activities carried out by, or on behalf of, the health insuring corporation and for ensuring that all requirements of sections 1751.77 to 1751.87 and Chapter 3922 of the Revised Code, and any rules adopted thereunder, are met. The health insuring corporation shall also ensure that appropriate personnel have operational responsibility for the conduct of the health insuring corporation's utilization review program.</p> <p>(2) If a health insuring corporation contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 1751.77 to 1751.87 and Chapter 3922 of the Revised Code, and any rules adopted thereunder, the superintendent of insurance shall hold the</p>

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		health insuring corporation responsible for monitoring the activities of the utilization review organization or other entity and for ensuring that the requirements of those sections and rules are met.
<p>Utilization, Internal and External Review – program requirements</p> <p><u>See definitions in ORC 1751.77</u></p> <p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>	ORC 1751.79	<p>A health insuring corporation that conducts utilization review shall prepare a written utilization review program that describes all review activities, both delegated and nondelegated, for covered health care services provided, including the following:</p> <p>(A) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;</p> <p>(B) The use of data sources and clinical review criteria in making decisions;</p> <p>(C) Mechanisms to ensure consistent application of criteria and compatible decisions;</p> <p>(D) Data collection processes and analytical methods used in assessing utilization of health care services;</p> <p>(E) Mechanisms for assuring confidentiality of clinical and proprietary information;</p> <p>(F) The periodic assessment of utilization review activities, and the reporting of these assessments to the health insuring corporation’s board, by a utilization review committee, a quality assurance committee, or any similar committee;</p> <p>(G) The functional responsibility for day-to-day program management by staff;</p> <p>(H) Defined methods by which guidelines are approved and communicated to providers and health care facilities.</p>
<p>Utilization, Internal and External Review – implementation</p> <p><u>See definitions in ORC 1751.77</u></p>	ORC 1751.80	<p>The utilization review program of a health insuring corporation shall be implemented in accordance with all of the following:</p> <p>(A) The program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health insuring corporation may develop its own clinical review criteria or may purchase or license such criteria from qualified vendors. A health insuring corporation shall make its clinical review rationale available upon request to authorized government agencies. The rationale made available to authorized government agencies is confidential</p>

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<p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>		<p>and is not a public record as defined in section 149.43 of the Revised Code.</p> <p>(B) Qualified providers shall administer the program and oversee review determinations. A clinical peer in the same, or in a similar, specialty as typically manages the medical condition, procedure, or treatment under review shall evaluate the clinical appropriateness of adverse determinations that are the subject of an appeal.</p> <p>(C) The health insuring corporation shall issue utilization review determinations in a timely manner pursuant to the requirements of sections 1751.81 and 1751.82 of the Revised Code and the enrollee grievance requirements. The health insuring corporation shall obtain information required to make a utilization review determination, including pertinent clinical information, and shall establish a process to ensure that utilization reviewers apply clinical review criteria consistently.</p> <p>(D) If the health insuring corporation delegates any utilization review activities to a utilization review organization, the health insuring corporation shall maintain adequate oversight, including a process by which the health insuring corporation evaluates the performance of the organization, and shall maintain copies of both of the following:</p> <p>(1) A written description of the organization's activities and responsibilities, including reporting requirements;</p> <p>(2) Evidence of formal approval of the organization's program by the health insuring corporation.</p> <p>(E) The health insuring corporation or its designee utilization review organization shall provide enrollees and participating providers with access to its review staff by means of a toll-free telephone number or collect-call telephone line.</p> <p>(F) When conducting prospective or concurrent review, the health insuring corporation or its designee utilization review organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of health care services.</p> <p>(G) Compensation to persons providing utilization review services for the health insuring corporation shall not contain incentives, direct or indirect, for them to make inappropriate review decisions.</p>
<p>Utilization, Internal and External Review – procedures for making</p>	<p>ORC 1751.81</p>	<p>(A) As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.</p> <p>(B) A health insuring corporation shall maintain written procedures for determining whether a</p>

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<p>determinations and providing notice</p> <p><u>See definitions in ORC 1751.77</u></p> <p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>		<p>requested service is a service covered under the terms of an enrollee's policy, contract, or agreement, making utilization review determinations, and notifying enrollees, participating providers, and health care facilities acting on behalf of enrollees, of its determinations.</p> <p>(C) For prospective review determinations, a health insuring corporation shall make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination.</p> <p>(1) In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification.</p> <p>(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.</p> <p>(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information.</p> <p>(1) In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification.</p> <p>(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee shall be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.</p> <p>(E) For retrospective review determinations, a health insuring corporation shall make the determination within thirty business days after receiving all necessary information.</p> <p>(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.</p> <p>(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five</p>

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		<p>business days after making the adverse determination.</p> <p>(F)(1) The time frames set forth in divisions (C), (D), and (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.</p> <p>(2) An enrollee, an authorized person, the enrollee's provider, or the health care facility rendering health care service to an enrollee may proceed with a request for an internal review pursuant to section 1751.83 of the Revised Code if a health insuring corporation fails to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section. The enrollee may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the enrollee.</p> <p>The health insuring corporation's failure to make a determination and notification within the time frames set forth in division (C), (D), or (E) of this section shall be deemed to be an adverse determination by the health insuring corporation for the purpose of initiating an internal review.</p> <p>(G) A written notification of an adverse determination shall include the principal reason or reasons for the determination, instructions for initiating a reconsideration of the determination under section 1751.82 of the Revised Code or an internal review under section 1751.83 of the Revised Code, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation shall provide the clinical rationale for an adverse determination in writing to any party who received notice of the adverse determination and who follows the instructions for a request.</p> <p>(H)(1) A health insuring corporation shall have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review.</p> <p>(2) A health insuring corporation shall not use unreasonable requests for information to delay making a determination.</p> <p>(3) If the health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification. An enrollee need not be granted an internal review pursuant to section 1751.83 of the Revised Code based on a health insuring corporation's failure to make a timely determination, if the health insuring corporation's delay in making a determination and notification is caused by the failure of a health care facility, provider, or enrollee to release all</p>

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		<p>necessary information, in which case the health insuring corporation shall notify the enrollee in writing of the reason for the delay.</p>
<p>Provider request for internal appeal</p> <p><u>See definitions in ORC 1751.77</u></p> <p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>	<p>ORC 1751.82</p>	<p>(A) In a case involving a prospective determination or a concurrent review determination, a health insuring corporation shall give the provider or health care facility rendering the health care service an opportunity to request in writing on behalf of the enrollee a reconsideration of an adverse determination by the reviewer making the adverse determination. The provider or health care facility may not request a reconsideration without the prior consent of the enrollee. The reconsideration shall occur within three business days after the health insuring corporation's receipt of the written request for reconsideration, and shall be conducted between the provider or health care facility rendering the health care service and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.</p> <p>(B) If the reconsideration process described in division (A) of this section does not resolve the difference of opinion, the enrollee, an authorized person, or the provider or health care facility acting on behalf of the enrollee may request an internal review under section 1751.83 of the Revised Code. The provider or health care facility may not request an internal review without the prior consent of the enrollee.</p> <p>(C) Reconsideration is not a prerequisite to an internal or external review of an adverse determination.</p> <p>(D) The time period allowed by division (A) of this section for a reconsideration of an adverse determination shall not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation shall maintain written procedures for making such an expedited reconsideration.</p>
<p>Internal appeal, superintendent review</p> <p><u>See definitions in ORC 1751.77</u></p>	<p>ORC 1751.83</p>	<p>A health insuring corporation shall establish and maintain an internal review system that has been approved by the superintendent of insurance. The system shall provide for review by a clinical peer and include adequate and reasonable procedures for review and resolution of appeals from enrollees concerning adverse determinations made under section 1751.81 of the Revised Code, including procedures for verifying and reviewing appeals from enrollees whose medical conditions require expedited review.</p> <p>A health insuring corporation shall consider and provide a written response to each request for an internal review not later than thirty days after receipt of the request, except that if the seriousness of</p>

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<p><u>Also see Internal Appeals and External Review sections under the Federal Form Review Requirements Checklist and the Chapter 3922 External Review checklist</u></p>		<p>the enrollee's medical condition requires an expedited review, the health insuring corporation shall provide the written response not later than seven days after receipt of the request or in accordance with applicable preemptive federal laws or regulations. The response shall state the reason for the health insuring corporation's decision, inform the enrollee of the right to pursue a further review, and explain the procedures for initiating the review, including the time frames within which the enrollee must request the review, as specified in section 3922.02 of the Revised Code. Failure by a health insuring corporation to provide a written response within the time frames specified under this section shall be deemed a denial by the health insuring corporation for purposes of requesting an external review under Chapter 3922. of the Revised Code.</p> <p>If the health insuring corporation has denied, reduced, or terminated coverage for a health care service on the grounds that the service is not a service covered under the terms of the enrollee's policy, contract, or agreement, the response shall inform the enrollee of the right to request a review by the superintendent of insurance under Chapter 3922 of the Revised Code. If the health insuring corporation has denied, reduced, or terminated coverage for a health care service on the grounds that the service is not medically necessary, the response shall inform the enrollee of the right to request an external review under Chapter 3922 of the Revised Code.</p> <p>The health insuring corporation shall make available to the superintendent for inspection copies of all documents in the health insuring corporation's possession related to reviews conducted pursuant to this section, including medical records related to those reviews, and of responses, for three years following completion of the review.</p>
<p>Direct access to participating OB or GYN</p> <p><u>Also see Network Plans PCP Requirements section under the Federal Form Review Requirements Checklist</u></p>	ORC 1753.13	<p>Every individual or group health insuring corporation policy, contract, or agreement that provides basic health care services but does not allow direct access to obstetricians or gynecologists shall permit a female enrollee to obtain covered obstetric and gynecological services from a participating obstetrician or gynecologist without obtaining a referral from the enrollee's primary care provider.</p> <p>No individual or group health insuring corporation policy, contract, or agreement may limit the number of allowable visits to a participating obstetrician or gynecologist. A health insuring corporation may require a participating obstetrician or gynecologist to comply with the health insuring corporation's coverage protocols and procedures, including utilization review, for obstetric and gynecological services.</p> <p>A health insuring corporation policy, contract, or agreement may not impose additional copayments for directly accessed obstetric and gynecological services, unless the policy, contract, or agreement imposes additional copayments for direct access to any participating provider other than a primary care provider.</p>

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<p>Procedures for standing referrals to specialists</p>	<p>ORC 1753.14</p>	<p>(A) A health insuring corporation that does not allow direct access to all specialists shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if a primary care provider determines in consultation with a specialist that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health insuring corporation in consultation with the primary care provider, a specialist, and the enrollee. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider with regular reports on the health care provided to the enrollee.</p> <p>(B) A health insuring corporation shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The procedure shall provide for such a referral if a primary care provider determines in consultation with the specialist that the enrollee needs the specialist's expertise. The referral shall be made pursuant to a treatment plan approved by the health insuring corporation in consultation with the primary care provider, the specialist, and the enrollee. After the referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.</p> <p>(C) The determinations described in divisions (A) and (B) of this section shall be made within three business days after a request for the determination is made by the enrollee or the enrollee's primary care provider and all appropriate medical records and other items of information necessary to make the determination have been provided.</p> <p>(D) Once a determination in favor of a referral is made, the referral shall be made within four business days after the determination. This time period does not apply to standing referrals involving a rare or unusual condition for which appropriate specialists are limited in number or otherwise difficult to identify.</p> <p>Divisions (A) and (B) of this section do not require a health insuring corporation to permit an enrollee to elect referral to a specialist who is not employed by or under contract with the health insuring corporation for the provision of health care services to the health insuring corporation's enrollees.</p>
<p>Access to prescription drugs</p>	<p>ORC 1753.21</p>	<p>(A) If a policy, contract, or agreement of a health insuring corporation uses a restricted formulary of prescription drugs, the health insuring corporation shall do both of the following:</p>

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		<p>(1) Develop such a formulary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of the members of which are physicians affiliated with the health insuring corporation who may prescribe prescription drugs and pharmacists affiliated with the health insuring corporation; or in consultation with and with the approval of a pharmacy and therapeutics committee that is independent of the health insuring corporation consisting of physicians who may prescribe prescription drugs in their state of licensure and pharmacists who are authorized to practice in their state of licensure;</p> <p>(2) Establish a procedure by which an enrollee may obtain, without penalty or additional cost sharing beyond that provided for formulary drugs under the enrollee's contract with the health insuring corporation, coverage of a specific nonformulary drug when the prescriber documents in the enrollee's medical record and certifies that the formulary alternative has been ineffective in the treatment of the enrollee's disease or condition, or that the formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the enrollee.</p> <p>(B) Nothing in this section shall be construed to require a health insuring corporation to place any particular pharmaceutical product or therapeutic class of product on any formulary, or to prohibit a health insuring corporation from restricting payments for any specific pharmaceutical product or therapeutic class of product, including, but not limited to, a requirement that the product be prescribed only by a defined specialist or subspecialist.</p>
<p>Coverage for emergency services</p> <p><u>Also see Emergency Services section under the Federal Form Review Requirements Checklist</u></p>	ORC 1753.28	<p>(A) As used in this section:</p> <p>(1) "Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:</p> <p>(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;</p> <p>(b) Serious impairment to bodily functions;</p> <p>(c) Serious dysfunction of any bodily organ or part.</p> <p>(2) "Emergency services" means the following:</p> <p>(a) A medical screening examination, as required by federal law, that is within the capability of the</p>

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		<p>emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;</p> <p>(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.</p> <p>(3)(a) "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:</p> <p>(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;</p> <p>(ii) Serious impairment to bodily functions;</p> <p>(iii) Serious dysfunction of any bodily organ or part.</p> <p>(b) In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.</p> <p>(4) "Transfer" has the same meaning as in section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.</p> <p>(B) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover emergency services for enrollees with emergency medical conditions without regard to the day or time the emergency services are rendered or to whether the enrollee, the hospital's emergency department where the services are rendered, or an emergency physician treating the enrollee, obtained prior authorization for the emergency services.</p> <p>(C) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover both of the following:</p> <p>(1) Emergency services provided to an enrollee at a participating hospital's emergency department if the enrollee presents self with an emergency medical condition;</p> <p>(2) Emergency services provided to an enrollee at a nonparticipating hospital's emergency department if the enrollee presents self with an emergency medical condition and one of the following</p>

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		<p>circumstances applies:</p> <p>(a) Due to circumstances beyond the enrollee's control, the enrollee was unable to utilize a participating hospital's emergency department without serious threat to life or health.</p> <p>(b) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a participating hospital's emergency department could result in one or more of the adverse health consequences described in division (A)(1) of this section.</p> <p>(c) A person authorized by the health insuring corporation refers the enrollee to an emergency department and does not specify a participating hospital's emergency department.</p> <p>(d) An ambulance takes the enrollee to a nonparticipating hospital other than at the direction of the enrollee.</p> <p>(e) The enrollee is unconscious.</p> <p>(f) A natural disaster precluded the use of a participating emergency department.</p> <p>(g) The status of a hospital changed from participating to nonparticipating with respect to emergency services during a contract year and no good faith effort was made by the health insuring corporation to inform enrollees of this change.</p> <p>(D) A health insuring corporation that provides coverage for emergency services shall inform enrollees of all of the following:</p> <p>(1) The scope of coverage for emergency services;</p> <p>(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;</p> <p>(3) Any cost sharing provisions for emergency services;</p> <p>(4) The procedures for obtaining emergency services and other medical services, so that enrollees are familiar with the location of the emergency departments of participating hospitals and with the location and availability of other participating facilities or settings at which they could receive medical services.</p>

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<p>Rewards or incentives for insurer wellness or health improvement programs</p> <p><u>Also see Wellness section under the Federal Form Review Requirements Checklist</u></p>	ORC 3901.56	<p>An insurer may offer a wellness or health improvement program that provides rewards or incentives, including merchandise; gift cards; debit cards; premium discounts or rebates; contributions to a health savings account; modifications to copayment, deductible, or coinsurance amounts; or any combination of these incentives, to encourage participation or to reward participation in the program.</p> <p>A wellness or health improvement program offered by an insurer under this section shall not be construed to violate division (E) of section 1751.31 or division (G) of section 3901.21 of the Revised Code if the program is disclosed in the policy or plan.</p> <p>The insured may be required to provide verification, such as a statement from their physician, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness or health improvement program.</p> <p>Nothing in this section shall prohibit an insurer from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise allowed by federal law.</p> <p>Nothing under division (C)(1) of section 3923.571 or section 3924.25 of the Revised Code shall be construed as prohibiting an insurer from offering a wellness or health improvement program or restricting the amount an employee is charged for coverage under a group policy after the application of any premium discounts or rebates, or modifying otherwise applicable copayments or deductibles for adherence to wellness or health improvement programs.</p> <p>For purposes of this section, "insurer" means a life insurance company, sickness and accident insurer, multiple employer welfare arrangement, public employee benefit plan, or health insuring corporation.</p>
<p>No coverage for non-therapeutic abortion</p> <p><u>Also see the No Coverage for Certain Abortions Services section of the Federal Form Review Requirements Checklist</u></p>	ORC 3901.87	<p>(A) No qualified health plan shall provide coverage for a nontherapeutic abortion.</p> <p>(B) As used in this section:</p> <p>(1) "Nontherapeutic abortion" has the same meaning as in section 124.85 of the Revised Code.</p> <p>(2) "Qualified health plan" means any qualified health plan as defined in section 1301 of the "Patient Protection and Affordable Care Act," 42 U.S.C. 18021 , offered in this state through an exchange created under that act.</p>

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Certification of non-English forms <u>See definitions in ORC 3902.02</u>	ORC 3902.03 (B)	(B) Any non-English language policy delivered or issued for delivery in this state is deemed to be in compliance with division (A)(1) of section 3902.04 of the Revised Code if the insurer certifies that such policy is translated from an English language policy that complies with division (A)(1) of section 3902.04 of the Revised Code.
Language, format and certification requirements <u>See definitions in ORC 3902.02</u>	ORC 3902.04	<p>(A) No policy forms, except as stated in section 3902.03 of the Revised Code, shall be delivered or issued for delivery in this state on or after the dates such forms must be approved under sections 3902.01 to 3902.08 of the Revised Code, unless:</p> <p>(1) The text achieves a minimum score of forty on the Flesch reading ease test, or an equivalent score on any other comparable test as provided in division (C) of this section;</p> <p>(2) It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded;</p> <p>(3) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy, or to any endorsements or riders;</p> <p>(4) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.</p> <p>(B) For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:</p> <p>(1) For policy forms containing ten thousand words or less of text, the entire form shall be analyzed. For policy forms containing more than ten thousand words, the readability of two two-hundred word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least twenty printed lines.</p> <p>(2) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen thousandths.</p> <p>(3) The total number of syllables shall be counted and divided by the total number of words. The</p>

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		<p>figure obtained shall be multiplied by a factor of eighty-four and six-tenths.</p> <p>(4) The sum of the figures computed under divisions (B)(2) and (3) of this section subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.</p> <p>(5) For purposes of divisions (B)(2), (3), and (4) of this section, the following procedures shall be used:</p> <p>(a) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.</p> <p>(b) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.</p> <p>(c) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.</p> <p>(6) As used in this section, "text" includes all printed matter, except the following:</p> <p>(a) The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, or tables;</p> <p>(b) Any policy language that is drafted to conform to the requirements of any federal law, regulation, or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words that are defined in the policy; and any policy language required by law or regulation; provided however, the insurer identifies the language or terminology excepted by this paragraph and certifies, in writing, that the language or terminology is entitled to be excepted by this paragraph.</p> <p>(C) Any other reading test may be approved by the superintendent of insurance for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.</p> <p>(D) Every filing subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used, or stating that the score is lower than the minimum required but should be approved in accordance with section 3902.06 of the Revised Code. To confirm the accuracy of any certification, the superintendent may</p>

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		<p>require the submission of further information to verify the certification in question.</p> <p>(E) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.</p>
<p>Coverage for routine patient care in eligible cancer clinical trial</p> <p><u>See definitions in ORC 3923.01 and 3923.011</u></p> <p><u>Also see Clinical Trials section under the Federal Form Review Requirements Checklist</u></p>	<p>ORC 3923.80</p>	<p>(A) Notwithstanding section 3901.71 of the Revised Code, no health benefit plan or public employee benefit plan shall deny coverage for the costs of any routine patient care administered to an insured participating in any stage of an eligible cancer clinical trial, if that care would be covered under the plan if the insured was not participating in a clinical trial.</p> <p>(B) The coverage that may not be excluded under division (A) of this section is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to any other coverage under the plan, policy, or arrangement for services performed by participating and nonparticipating providers. Nothing in this section shall be construed as requiring reimbursement to a provider or facility providing the routine care that does not have a health care contract with the entity issuing the health benefit plan or public employee benefit plan, or as prohibiting the entity issuing a health benefit plan or public employee benefit plan that does not have a health care contract with the provider or facility providing the routine care from negotiating a single case or other agreement for coverage.</p> <p>(C) As used in this section:</p> <p>(1) “Eligible cancer clinical trial” means a cancer clinical trial that meets all of the following criteria:</p> <p>(a) A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes.</p> <p>(b) The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes.</p> <p>(c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.</p> <p>(d) The trial does one of the following:</p>

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		<p>(i) Tests how to administer a health care service, item, or drug for the treatment of cancer;</p> <p>(ii) Tests responses to a health care service, item, or drug for the treatment of cancer;</p> <p>(iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;</p> <p>(iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.</p> <p>(e) The trial is approved by one of the following entities:</p> <p>(i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;</p> <p>(ii) The United States food and drug administration;</p> <p>(iii) The United States department of defense;</p> <p>(iv) The United States department of veterans' affairs.</p> <p>(2) "Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.</p> <p>(3) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.</p> <p>(4) "Routine patient care" means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.</p> <p>(5) For purposes of this section, a health benefit plan or public employee benefit plan may exclude coverage for any of the following:</p> <p>(a) A health care service, item, or drug that is the subject of the cancer clinical trial;</p>

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		<p>(b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;</p> <p>(c) An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration;</p> <p>(d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;</p> <p>(e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;</p> <p>(f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.</p>
<p>Covered person's payments not to exceed insurer payments</p> <p><u>See definitions in ORC 3923.01 and 3923.011</u></p>	<p>ORC 3923.81</p>	<p>(A) If a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement and the person is required to pay for health care costs out-of-pocket or with funds from a savings account, the amount the person is required to pay to a health care provider or pharmacy shall not exceed the amount the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement would pay under applicable reimbursement rates negotiated with the provider or pharmacy. This division does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated, except that a health care provider or pharmacy shall not waive all or part of a copay or deductible if prohibited by any other provision of the Revised Code. The requirements of this division do not apply to amounts owed to a provider or pharmacy with whom the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement has no applicable negotiated reimbursement rate.</p> <p>(B) Each sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement shall establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out of pocket costs for services provided by in-network providers.</p> <p>(C) As used in this section:</p>

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
		<p>(1) "Health benefit plan" means any policy of sickness and accident insurance or any policy, contract, or agreement covering one or more "basic health care services," "supplemental health care services," or "specialty health care services," as defined in section 1751.01 of the Revised Code, offered or provided by a health insuring corporation or by a sickness and accident insurer or multiple employer welfare arrangement.</p> <p>(2) "Reimbursement rates" means any rates that apply to a payment made by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement for charges covered by a health benefit plan.</p> <p>(3) "Savings account" includes health savings accounts, health reimbursement arrangements, flexible savings accounts, medical savings accounts, and similar accounts and arrangements.</p>
<p>Health care benefit plans covered by chapter – exceptions</p> <p><u>See definitions in ORC 3924.01</u></p>	<p>ORC 3924.02 (B)</p>	<p>(B) Notwithstanding division (A) of this section, divisions (D), (E)(2), (F), and (G) of section 3924.03 of the Revised Code and section 3924.04 of the Revised Code do not apply to health benefit policies that are not sold to owners of small businesses as an employment benefit plan. Such policies shall clearly state that they are not being sold as an employment benefit plan and that the owner of the business is not responsible, either directly or indirectly, for paying the premium or benefits.</p>
<p>Health care benefit plans covering small employers subject to conditions – creditable coverage</p> <p><u>See definitions in ORC 3924.01</u></p> <p><u>Also see Pre-Existing section of the Federal Form Review Requirements Checklist</u></p>	<p>ORC 3924.03 (A)(3)(4)</p>	<p>(A)(3) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health benefit plan, if, after that period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage. Subsections (c)(2) to (4) and (e) of section 2701 of the "Health Insurance Portability and Accountability Act of 1996" apply with respect to crediting previous coverage.</p> <p>(4) As used in division (A) of this section:</p> <p>(a) "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996."</p> <p>(b) "Enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.</p>

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
<p>Health care benefit plans covering small employers subject to conditions – guaranteed renewable</p> <p><u>See definitions in ORC 3924.01</u></p> <p><u>Also see Guaranteed Renewable sections of the Federal Form Review Requirements Checklist</u></p>	ORC 3924.03 (B)	<p>(B)(1) Except as provided in section 2712(b) to (e) of the “Health Insurance Portability and Accountability Act of 1996,” if a carrier offers coverage in the small employer market in connection with a group health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.</p>
<p>Health care benefit plans covering small employers subject to conditions – contributions, special enrollment</p> <p><u>See definitions in ORC 3924.01</u></p> <p><u>Also see Special Enrollment section of the Federal Form Review Requirements Checklist</u></p>	ORC 3924.03 (E)	<p>(E)(1) Except as provided in sections 3924.031 and 3924.032 of the Revised Code, and subject to such rules as may be adopted by the superintendent of insurance in accordance with Chapter 119 of the Revised Code, a carrier shall offer and make available every health benefit plan that it is actively marketing to every small employer that applies to the carrier for such coverage.</p> <p>Division (E)(1) of this section does not apply to a health benefit plan that a carrier makes available in the small employer market only through one or more bona fide associations.</p> <p>Division (E)(1) of this section shall not be construed to preclude a carrier from establishing employer contribution rules or group participation rules for the offering of coverage in connection with a group health benefit plan in the small employer market, as allowed under the law of this state. As used in division (E)(1) of this section, “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents and “group participation rule” means a requirement relating to the minimum number of employees or dependents that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.</p> <p>(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting periods</p>

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		<p>shall not be greater than ninety days.</p> <p>(3) Each health benefit plan shall provide for the special enrollment periods described in section 2701(f) of the “Health Insurance Portability and Accountability Act of 1996.”</p> <p>(4) At least once in every twelve-month period, a carrier shall provide to all late enrollees who are identified by the small employer, the option to enroll in the health benefit plan. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the health benefit plan, including any pre-existing condition exclusion period, affiliation period, or service waiting period, shall begin on the date the carrier receives notice of the late enrollee’s application or request for coverage, and shall run concurrently with each other.</p>
Overcharges	ORC 3924.21	<p>(A) As used in this section:</p> <p>(1) “Beneficiary,” “hospital,” and “third-party payer” have the same meanings as in section 3901.38 of the Revised Code.</p> <p>(2) “Overcharged” means charged more than the usual and customary charge, rate, or fee that is charged by the provider or hospital for a particular item or service.</p> <p>(3) “Provider” has the same meaning as in section 3902.11 of the Revised Code.</p> <p>(B) If a beneficiary identifies on the billing statement of a provider or hospital any item or service for which the beneficiary was overcharged by more than five hundred dollars and the beneficiary notifies the third-party payer of the error at any time after the thirty-day period immediately following the date on which the third-party payer makes payment to the provider or hospital for the item or service, the provider or hospital shall refund to the beneficiary an amount equal to fifteen per cent of the amount overcharged.</p> <p>(C) A provider or hospital shall not be required to comply with division (B) of this section if, at the time the third-party payer receives notice of the overcharge from the beneficiary, the provider, hospital, or third-party payer is in the process of correcting the error and such process can be documented.</p>
Plan benefits for adopted children	ORC 3924.51	<p>(A) As used in this section:</p> <p>(1) “Child” means, in connection with any adoption or placement for adoption of the child, an</p>

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		<p>individual who has not attained age eighteen as of the date of the adoption or placement for adoption.</p> <p>(2) "Health insurer" has the same meaning as in section 3924.41 of the Revised Code.</p> <p>(3) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of that legal obligation.</p> <p>(B) If an individual or group health plan of a health insurer makes coverage available for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.</p> <p>(C) A health plan described in division (B) of this section shall not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.</p>
<p>Coverage for person in custody or confined in jail</p>	<p>ORC 3924.53</p>	<p>(A) As used in this section:</p> <p>(1) "Beneficiary" and "benefits contract" have the same meanings as in section 3901.38 of the Revised Code.</p> <p>(2) "Confinement" means any period of time during which a person is in the custody or under the supervision of the department of rehabilitation and correction or is confined in a local jail, workhouse, or other correctional facility of the type described in section 307.93, 341.14, 341.19, 341.23, 753.02, 753.04, 753.16, 2301.56, or 2947.19 of the Revised Code.</p> <p>(3) "Law enforcement officer" has the same meaning as in section 2901.01 of the Revised Code.</p> <p>(B) Except as provided in division (C) of this section, no benefits contract shall limit or exclude coverage for the reason that the beneficiary is under confinement or is otherwise under the custody of a law enforcement officer, and a governmental entity is wholly or primarily responsible for rendering or arranging for the rendering of health care services for the beneficiary.</p>

SMALL GROUP HIC EOC Filing Guidance – FORM REVIEW REQUIREMENTS

TOIS: HOrg02G.004F Small Group Health Organizations – Health Maintenance (HMO) – Small Group ONLY

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		(C) A benefits contract may limit or exclude coverage for health care services rendered to such a beneficiary if the injury or sickness for which the services were rendered resulted from an action or omission for which the governmental entity operating the correctional facility, or the governmental entity with which the law enforcement officer is affiliated, is liable.
Coordination of benefits - required language <u>See definitions in OAC 3901-8-01 (C)</u>	OAC 3901-8-01 (D)(2)	<p>(2) The following language shall be included as a separate and distinct paragraph on the first page in every contract, policy, certificate/evidence of coverage and summary plan description issued to a beneficiary under a plan subject to this rule, and shall be printed in twelve-point type:</p> <p>“NOTICE: 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. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.”</p>
Coordination of benefits - Appendix A language required <u>See definitions in OAC 3901-8-01 (C)</u>	OAC 3901-8-01 (D)(3)(4)	<p>(3) A contract which utilizes “COB” shall contain the “COB” provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No substantive changes are permitted.</p> <p>(4) Each certificate issued under a group contract which utilizes “COB” shall contain the “COB” provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the group certificate or to reflect the difference among plans which provide services, which pay benefits for expenses incurred and which indemnify. No substantive changes are permitted.</p>
Notice regarding policies or certificates which are not Medicare supplement policies	OAC 3901-8-08 (S)(5)(a)	<p>(a) Any sickness and accident insurance policy or certificate, other than a medicare supplement policy or a policy issued pursuant to a contract under section 1876 of the federal “Social Security Act” (42 U.S.C. section 1395, et seq.); disability income policy; or other policy identified in paragraph (C)(2) of this rule, issued for delivery in this state to persons eligible for medicare shall notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve-point type and shall contain the following language:</p> <p>“This (policy or certificate) is not a medicare supplement (policy or certificate). If you are eligible for medicare, review the “Guide to Health Insurance for People with Medicare” available from the company.”</p>

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
<p>Complaint Procedure</p> <p><u>Also see the Chapter 3922 External Review Checklist and the Internal Appeals and External Review sections of the Federal Form Review Requirements Checklist for more requirements</u></p>	OAC 3901-8-11 (H)	<p>(H) Complaint procedure</p> <p>Every third-party payer shall:</p> <p>(1) Establish and maintain a procedure for the expeditious resolution of electronic written, and oral complaints initiated by beneficiaries and providers.</p> <p>(2) Include the third party payer’s complaint procedure in every benefit plan contract or certificate.</p> <p>(3) Keep records of written complaints from and responses to beneficiaries and providers for three years.</p> <p>(4) Include the following statement or a substantially similar statement on all notification of claim denials:</p> <p>“If you wish to dispute the company’s decision on this claim, you may register a complaint by (insert third-party payer’s procedure): (insert address of office). In reviewing your complaint, the company will follow the complaint procedure described in your benefits plan.”</p> <p>(5) Include the following statement on the written notice to the beneficiary and the provider of the company’s final adjudication of a complaint:</p> <p>“If your claim has been denied on the basis that the service is not medically necessary, or you have been diagnosed with a terminal condition and the service has been denied on the basis that it is experimental or investigational, you may have a right to request an independent review by an outside medical practitioner. Submit your request in writing to (insert address of third-party payer).</p> <p>If your claim has been denied on the basis that it is not a covered service you have the right to file a complaint with the “Ohio Department of Insurance. Consumer Services Division. 50 West Town Street. Third Floor – Suite 300. Columbus. Ohio 43215. (614V644-2673. toll free in Ohio 1-800-686-1526.” Complaints may also be filed via the internet at http://insurance.ohio.gov.”</p>