SMALL GROUP POLICY/CERTIFICATE Filing Guidance – FORM REVIEW REQUIREMENTS
TOIS: H16G Group Health – Major Medical
Sub TOIs: ☐.003A PPO ☐.003D POS ☐.003G Other

REVIEW REQUIREMENT	AUTHORITY	DESCRIPTION
Rewards or incentives for insurer wellness or health improvement programs **Also see Wellness section of the Federal Form Review Requirements Checklist**	ORC 3901.56	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. 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. 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. 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. 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. 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.
No Coverage for non-therapeutic abortion **Also see the No Coverage for Certain Abortions Services section of the Federal Form Review Requirements Checklist**	ORC 3901.87	(A) No qualified health plan shall provide coverage for a nontherapeutic abortion. (B) As used in this section: (1) "Nontherapeutic abortion" has the same meaning as in section 124.85 of the Revised Code. (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.

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Certification of non-English forms **See definitions in ORC 3902.02**	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 **See definitions in ORC 3902.02**	ORC 3902.04	(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: (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; (2) It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded; (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; (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. (B) For the purposes of this section, a Flesch reading ease test score shall be measured by the following method: (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. (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. (3) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths. (4) The sum of the figures computed under divisions (B)(2) and (3) of this section subtracted from

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		two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form. (5) For purposes of divisions (B)(2), (3), and (4) of this section, the following procedures shall be used: (a) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word. (b) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence. (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. (6) As used in this section, “text” includes all printed matter, except the following: (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; (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. (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. (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 require the submission of further information to verify the certification in question. (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.

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Standard provisions **See definitions in ORC 3923.01 and 3923.011** **Only those items applicable under ORC 3923.20 are shown.** **(For complete text, please refer to the Ohio Revised Code)**	ORC 3923.04	Except as provided in section 3923.07 of the Revised Code, every policy of sickness and accident insurance delivered, issued for delivery, or used in this state shall contain the standard provisions specified in this section in the words in which the same appear in this section. Such standard provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent of insurance may approve. (E) Notice of claim (G) Proofs of loss (H) Time payment of claims (K) Legal actions
Non-conflicting provisions permitted in policy **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.08	Any foreign or alien insurer authorized to do business in this state may, with the approval of the superintendent of insurance, insert in any policy of sickness and accident insurance, delivered, issued for delivery, or used in this state, any provision required by the laws of the state or the country in which such insurer is domiciled, if such provision is not substantially in conflict with any law of this state. Any domestic insurer may insert in any such policy issued for delivery in another state or foreign country, and governed by the laws thereof, any provision required by the laws of such other state or country applicable to such policy.
Group sickness and accident insurance – description, definitions and required provisions **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.12 (A)(B)(C)	(A) Group sickness and accident insurance is that form of sickness and accident insurance covering any group of two or more employees, members, or other persons, with or without one or more of their dependents and members of their immediate families. Such insurance may be offered to groups without regard to the purpose or type of group or the occupation of the employees, members, or other persons insured under the policy. (B) As used in this section: (1) "Employees" includes the officers, managers, and employees of the employer, the partners, if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise.

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		(2) "Employer" includes any municipal or governmental corporation, unit, agency, or department thereof, as well as private individuals, partnerships, and corporations. (C) Each such policy shall contain in substance the following provisions: (1) A provision that the policy, the application of the policyholder, if the application or copy thereof is attached to the policy, and the individual applications submitted in connection with the policy by the employees or members, shall constitute the entire contract between the parties, and that all statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties, and that no such statement shall avoid the insurance or reduce benefits thereunder unless contained in a written application; (2) A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits thereunder are payable. If dependents or members of the immediate family of the employee or member are included in the coverage, only one certificate need be issued for each family unit. (3) A provision that to the group originally insured may be added from time to time eligible new employees or members, their dependents, or members of their immediate families, in accordance with the terms of the policy.
Option for conversion from group policy to individual policy – eligibility and specifications **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.122 (A)(B)(C)(D)	Suspended effective 1/1/2014 through 1/1/2018 (Ohio Senate Bill 9, 130th GA)
Option for conversion from group policy to individual policy – extension for late notice	ORC 3923.122 (H)	Suspended effective 1/1/2014 through 1/1/2018 (Ohio Senate Bill 9, 130th GA)

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See definitions in ORC 3923.01 and 3923.011		
Certain policies exempted **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.20	Sections 3923.03 to 3923.07, inclusive, of the Revised Code, do not apply to those forms of sickness and accident policies enumerated in sections 3923.12 and 3923.13 of the Revised Code, provided that no such policy shall contain any provision relative to notice or proof of loss, or the time for paying benefits, or the time within which suit may be brought upon the policy, which in the opinion of the superintendent of insurance is less favorable to the insured than would be permitted by the standard provisions set forth in section 3923.04 of the Revised Code.
Reimbursement for services of licensed osteopath, optometrist, chiropractor or podiatrist **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.23	Notwithstanding any provision of any certificate furnished by an insurer in connection with, or pursuant to any group sickness and accident insurance policy delivered, issued for delivery, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980, and notwithstanding any provision of any policy of insurance delivered, issued for delivery, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980, whenever such policy or certificate is subject to the jurisdiction of this state and provides for reimbursement for any service which may be legally performed by a person licensed in this state for the practice of osteopathy, optometry, chiropractic, or podiatry, reimbursement under such policy or certificate shall not be denied when such service is rendered by a person so licensed.
Reimbursement for services of licensed psychologist **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.231	Notwithstanding any provision of any certificate furnished by an insurer in connection with, or pursuant to any group sickness and accident insurance policy delivered, issued, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980, and notwithstanding any provision of any policy of insurance delivered, issued for delivery, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980, whenever such policy or certificate is subject to the jurisdiction of this state and provides for reimbursement for any service that may be legally performed by a person licensed in this state as a psychologist as defined in division (A) of section 4732.01 of the Revised Code, reimbursement under such policy or certificate shall not be denied when such service is rendered by a person so licensed who has received a doctorate of psychology or has a minimum of five years clinical experience.
Reimbursement for services of licensed dentist	ORC 3923.232	Notwithstanding any provision of any certificate furnished by an insurer in connection with, or pursuant to any group sickness and accident insurance policy delivered, issued, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980, and notwithstanding any provision of any policy of insurance delivered, issued for delivery, renewed or used, in or outside this state, on or after the effective date of this amendment, July 1, 1980,

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See definitions in ORC 3923.01 and 3923.011		whenever such policy or certificate is subject to the jurisdiction of this state and provides for reimbursement for any service that may be legally performed by a person licensed in this state for the practice of dentistry, reimbursement under such policy or certificate shall not be denied when such service is rendered by a person so licensed.
Reimbursement for services of certified nurse-midwife performing service in collaboration with licensed physician **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.233	Notwithstanding any provision of any certificate furnished by an insurer in connection with or pursuant to any group sickness and accident insurance policy delivered, issued, renewed, or used, in or outside this state, on or after January 1, 1985, and notwithstanding any provision of any policy of insurance delivered, issued for delivery, renewed, or used, in or outside this state, on or after January 1, 1985, whenever the policy or certificate is subject to the jurisdiction of this state and provides for reimbursement for any service that may be legally performed by a certified nurse-midwife who is authorized under section 4723.42 of the Revised Code to practice nurse-midwifery, reimbursement under the policy or certificate shall not be denied to a certified nurse-midwife performing the service in collaboration with a licensed physician. The collaborating physician shall be identified on an insurance claim form. The cost of collaboration with a certified nurse-midwife by a licensed physician as required under section 4723.43 of the Revised Code is a reimbursable expense. The division of any reimbursement payment for services performed by a certified nurse-midwife between the nurse-midwife and the nurse-midwife's collaborating physician shall be determined and mutually agreed upon by the certified nurse-midwife and the physician. The division of fees shall not be considered a violation of division (B)(17) of section 4731.22 of the Revised Code. In no case shall the total fees charged exceed the fee the physician would have charged had the physician provided the entire service.
Reimbursement for services of certified mechanotherapist **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.234	Notwithstanding any provision of any certificate furnished by an insurer in connection with, or pursuant to any group sickness and accident insurance policy delivered, issued, renewed, or used, in or outside this state, on or after July 20, 1988, and notwithstanding any provision of any policy of insurance delivered, issued for delivery, renewed, or used, in or outside this state, on or after July 20, 1988, whenever the policy or certificate is subject to the jurisdiction of this state and provides for reimbursement for any service that may be legally performed by a mechanotherapist, who was issued a certificate as a mechanotherapist under section 4731.15 of the Revised Code and practices in accordance with rules adopted under section 4731.151 of the Revised Code, reimbursement under the policy or certificate shall not be denied when the service is rendered by a person so registered, but only if that person completed educational requirements in mechanotherapy on or before November 3, 1975.

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		As used in this section, "educational requirements" has the same meaning as in section 4731.151 of the Revised Code.
Continuing coverage for dependent children **See definitions in ORC 3923.01 and 3923.011** **Also see the Dependent Coverage up to Age 26 section under Federal Form Review Requirements Checklist**	ORC 3923.24	(A) Notwithstanding section 3901.71 of the Revised Code, every certificate furnished by an insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, and every multiple employer welfare arrangement offering an insurance program, which provides that coverage of an unmarried dependent child of a parent or legal guardian will terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance both of the following: (1)Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, upon the request of the insured, the insurer shall offer to cover the unmarried child until the child attains twenty-eight years of age if all of the following are true: (a) The child is the natural child, stepchild, or adopted child of the insured. (b) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education. (c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage. (d) The child is not eligible for coverage under the medicaid program established under Chapter 5111. of the Revised Code or the medicare program established under Title XVIII of the "Social Security Act," 42 U.S.C. 1395. (2)That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following: (a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;

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		(b) Primarily dependent upon the policyholder or certificate holder for support and maintenance. (B) Proof of such incapacity and dependence for purposes of division (A)(2) of this section shall be furnished by the policyholder or by the certificate holder to the insurer within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually after the two-year period following the child's attainment of the limiting age, the insurer may require proof satisfactory to it of the continuance of such incapacity and dependency. (C)Nothing in this section shall require an insurer to cover a dependent child who is mentally retarded or physically handicapped if the contract is underwritten on evidence of insurability based on health factors set forth in the application, or if such dependent child does not satisfy the conditions of the contract as to any requirement for evidence of insurability or other provision of the contract, satisfaction of which is required for coverage thereunder to take effect. In any such case, the terms of the contract shall apply with regard to the coverage or exclusion of the dependent from such coverage. Nothing in this section shall apply to accidental death or dismemberment benefits provided by any such policy of sickness and accident insurance. (D)Nothing in this section shall do any of the following: (1) Require that any policy offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the policy; (2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the policy; (3) Require an employer to offer health insurance coverage to the dependents of any employee. (E)This section does not apply to any policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of not longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. (F)As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the

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		Revised Code and also includes both of the following: (1)A public employee benefit plan; (2)A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.
Kidney dialysis benefit **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.25	Every certificate furnished by an insurer in connection with, or pursuant to any provision of any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state, provided such policy was delivered, issued for delivery, or renewed on or after July 1, 1972, and every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state, provided such policy was delivered, issued for delivery, or renewed on or after July 1, 1972, which provides for kidney dialysis benefits, shall be deemed to include such benefits on an equal basis if the dialysis is performed on an out-patient basis. For purpose of this section, "out-patient basis" includes care rendered at any location whether or not at a hospital, upon approval by the attending physician.
Coverage for newly born children from the moment of birth **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.26	Every group policy or certificate of sickness and accident insurance delivered, issued for delivery, or renewed in this state providing coverage on an expense-incurred basis, and every individual policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state which provides coverage on an expense-incurred basis, either of which makes coverage available for family members of the insured, shall, as to such family members' coverage, also provide that any sickness and accident insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for an additional child, the certificate or policy may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth in order to have the coverage continue beyond such period.
Outpatient coverage for mental or emotional disorders	ORC 3923.28	(A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1979, and that provides coverage for mental or emotional disorders, shall provide benefits for services on an outpatient basis for each eligible person under the policy who resides in this state for mental or emotional disorders, or for evaluations,

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See definitions in ORC 3923.01 and 3923.011 **Also see Mental Health and Substance Use Disorder Parity section under the Federal Form Review Requirements Checklist**		that are at least equal to five hundred fifty dollars in any calendar year or twelve-month period. The services shall be legally performed by or under the clinical supervision of a physician authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732 of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757 of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723 of the Revised Code whose nursing specialty is mental health, whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the joint commission on accreditation of healthcare organizations, the council on accreditation for children and family services, or the rehabilitation accreditation commission. (B) Outpatient benefits offered under division (A) of this section shall be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. Persons entitled to such benefit under more than one service or insurance contract may be limited to a single five-hundred-fifty-dollar outpatient benefit for services under all contracts. (C) In order to qualify for participation under division (A) of this section, every facility specified in such division shall have in effect a plan for utilization review and a plan for peer review and every person specified in such division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services. (D) Nothing in this section shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable. (E)(1) Services performed under the clinical supervision of a health care professional identified in division (A) of this section, in order to be reimbursable under the coverage required in division (A) of this section, shall meet both of the following requirements: (a) The services shall be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed; (b) The plan shall be reviewed and approved by the health care professional every three months. (2) Payment of benefits for services reimbursable under division (E)(1) of this section shall not be restricted to services described in the treatment plan or conditioned upon standards of clinical supervision that are more restrictive than standards of a health care professional described in division (A) of this section, which at least equal the requirements of division (E)(1) of this section. (F) The benefits provided by this section for mental and emotional disorders shall not be reduced by

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		the cost of benefits provided pursuant to section 3923.281 of the Revised Code for diagnostic and treatment services for biologically based mental illnesses. This section does not apply to benefits for diagnostic and treatment services for biologically based mental illnesses.
Sickness and accident policies - biologically based mental illness **See definitions in ORC 3923.01 and 3923.011** **Also see Mental Health and Substance Use Disorder Parity section under the Federal Form Review Requirements Checklist**	ORC 3923.281 (A)(B)(C)(D)	(A) As used in this section: (1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association. (2) "Policy of sickness and accident insurance" has the same meaning as in section 3923.01 of the Revised Code, but excludes any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of not longer than six months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; and any policy that provides coverage to medicaid recipients. (B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (E) of this section, every policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply: (1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health. (2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards. (C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles.

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		(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions: (1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; (2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses; (3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary; (4) Enforcing the terms and conditions of a policy of sickness and accident insurance.
Outpatient, inpatient, and intermediate primary care benefits for alcoholism **See definitions in ORC 3923.01 and 3923.011** **Also see Mental Health and Substance Use Disorder Parity section under the Federal Form Review Requirements Checklist**	ORC 3923.29	(A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1979, shall provide for each eligible person under the policy who resides in this state, outpatient, inpatient, and intermediate primary care benefits for alcoholism that are at least equal to five hundred fifty dollars in any calendar year or twelve month period. The services shall be legally performed by or under the clinical supervision of a licensed physician or a licensed psychologist, whether performed in an office, in a hospital, in a community mental health facility, or in an alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission on accreditation of hospitals or certified by the department of health. (B) The benefits mandated by division (A) of this section shall be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. Persons entitled to such benefit under more than one service or insurance contract may be limited to a single five hundred fifty dollar benefit for services under all contracts. (C) For an eligible person, who receives treatment for alcoholism from an approved or certified alcoholism treatment facility, to remain entitled to the benefits mandated by division (A) of this section, a licensed physician or a licensed psychologist shall every three months certify that such person needs to continue utilizing such treatment. (D) In order to qualify for participation under division (A) of this section, every facility specified in such division shall have in effect a plan for utilization review and a plan for peer review and every

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		person specified in such division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services. Such person or facility shall also have in effect a program of rehabilitation or a program of rehabilitation and detoxification. (E) Nothing in this section shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable.
Excluding coverage of illness or injury covered by workers' compensation **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.36	No sickness and accident insurance policy shall be construed to exclude illness or injury upon the ground that the insured might have elected to have such illness or injury covered by workers' compensation under division (A)(3) of section 4123.01 of the Revised Code unless the policy clearly excludes work or occupational related illness or injury or the policy, or a separate writing signed by the insured, informs the insured 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.
Continuing policy upon termination of employment – definitions, requirement and specifications **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.38 (A)(B)(C)	(A) As used in this section: (1) "Group policy" includes any group sickness and accident policy or contract delivered, issued for delivery, or renewed in this state on or after June 28, 1984, and any private or public employer self-insurance plan or other plan that provides, or provides payment for, health care benefits for employees resident in this state other than through an insurer or health insuring corporation, to which both of the following apply: (a) The policy insures employees for hospital, surgical, or major medical insurance on an expense incurred or service basis, other than for specified diseases or for accidental injuries only. (b) The policy is in effect and covers an eligible employee at the time the employee's employment is terminated. (2) "Eligible employee" includes only an employee to whom all of the following apply: (a) The employee has been continuously insured under a group policy or under the policy and any prior similar group coverage replaced by the policy, during the entire three-month period preceding

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		the termination of the employee's employment. (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. (c) The employee is not, and does not become, covered by or eligible for coverage by medicare under Title XVIII of the Social Security Act, as amended. (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 person was not covered immediately prior to such termination. 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. (3) "Group rate" means, in the case of an employer self-insurance or other health benefits plan, the average monthly cost per employee, over a period of at least twelve months, of the operation of the plan that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy. (B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of twelve months after the date that the insurance coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage, or other notice of coverage, issued to employees under the policy shall include a notice of the employee's privilege of continuation. (C) All of the following apply to the continuation of coverage required under division (B) of this section: (1) Continuation need not include dental, vision care, or any other benefits provided under the policy in addition to its hospital, surgical, or major medical benefits. (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

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		amount of contribution required by the employer under division (C)(4) of this section. (3) The employee shall file a written election of continuation with the employer and pay the employer 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: (a) Thirty-one days after the date on which the employee's coverage would otherwise terminate; (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 such date; (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. (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. (5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs: (a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section; (b) A period of twelve months expires after the date that the employee's insurance under the policy would otherwise have terminated because of the termination of employment; (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; (d) The policy is terminated, or the employer terminates participation under the policy, unless the employer replaces the coverage by similar coverage under another group policy or other group health arrangement. If the employer replaces the policy with similar group health coverage, all of the following apply:

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		(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. (ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the policy replaced reduced by any benefits payable under the policy replaced. (iii) The policy replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.
Continuing coverage under group policy when reservist is called or ordered to active duty – definitions, requirements and specifications **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.381 (A)(B)(C)(D)(E)(F)(G)	(A) As used in this section: (1) "Eligible person" means any person who, at the time a reservist is called or ordered to active duty, is covered under a group policy and is either of the following: (a) An employee who is a reservist called or ordered to active duty; (b) The spouse or a dependent child of an employee described in division (A)(1)(a) of this section. (2) "Group policy" includes any group sickness and accident insurance policy that satisfies all of the following: (a) The policy is delivered, issued for delivery, or renewed in this state on or after April 17, 1991. (b) The policy covers employees for hospital, surgical, or major medical insurance on an expense incurred or service basis, other than for specified diseases or accidental injuries only. (c) The policy is in effect and covers an eligible person at the time a reservist is called or ordered to active duty. (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. (B) Every group policy shall provide that any eligible person may continue the coverage under the policy for a period of eighteen months after the date on which the coverage would otherwise

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		terminate because the reservist is called or ordered to active duty. (C)(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 period: (a) The death of the reservist; (b) The divorce or separation of a reservist from the reservist's spouse; (c) The cessation of dependency of a child pursuant to the terms of the policy. (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. (3) The employer may begin the thirty-six-month period on the date of any occurrence described in division (C)(1) of this section. (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: (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 policy and an employee who has not been called or ordered to active duty. (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. (3) Each certificate of coverage issued by an insurer to an employee under the group policy shall include a notice of the eligible person's right of continuation of coverage. (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

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		employer no later than thirty-one days after the date of the notification. (5)(a) Except as provided in division (D)(5)(b) or (c) of this section, the eligible person shall pay to the 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 policy on the due date of each payment. (b) The employer may pay a portion or all of the eligible person's contribution. (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. (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: (1) The eligible person, whether as an employee or otherwise, enrolls in another group policy 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 policy 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. (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. (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. (4) The group policy, or participation under the group policy, is terminated, unless the employer, in accordance with division (F) of this section, replaces the coverage with similar coverage under another group policy or other group health plan or arrangement. (F) If the employer replaces the group policy with similar coverage as described in division (E)(4) of this section, both of the following apply: (1) The eligible person is covered under the replacement coverage for the balance of the period that the eligible person would have remained covered under the terminated coverage if it had not been

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		terminated. (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 policy and an employee who has not been called or ordered to active duty. (G) Upon the reservist's release from active duty and return to employment for the employer by whom the reservist was employed at the time of being called or ordered to active duty, both of the following apply: (1) Every eligible person is entitled, without any waiting period, to coverage under the employer's group policy that is in effect at the time of the reservist's return to employment. (2) Every eligible person is entitled to all benefits under the group policy described in division (G)(1) of this section from the date of the original coverage under the policy.
Coverage of adopted children **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.40	No individual or group policy of sickness and accident insurance that makes family coverage available may be delivered, issued for delivery, or renewed in this state on or after January 1, 1989, unless the policy covers adopted children of the insured on the same basis as other dependents. The coverage required by this section is subject to the requirements and restrictions set forth in section 3924.51 of the Revised Code.
Screening mammography and cytologic screening benefits **See definitions in ORC 3923.01 and 3923.011** **Also see Preventive Services section**	ORC 3923.52	(A) As used in this section and section 3923.53 of the Revised Code, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women 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. "Screening mammography" does not include diagnostic mammography. (B) Every policy of individual or group sickness and accident insurance that is delivered, issued for

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under the Federal Form Review Requirements Checklist		delivery, or renewed in this state shall provide benefits for the expenses of both of the following: (1) Screening mammography to detect the presence of breast cancer in adult women; (2) Cytologic screening for the presence of cervical cancer. (C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following: (1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography; (2) If a woman is at least forty years of age but under fifty years of age, either of the following: (a) One screening mammography every two years; (b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year. (3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year. (D) As used in this division, “medicare reimbursement rate” means the reimbursement rate paid in this state 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. (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 paid by medicare in this state for that component. (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

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		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. (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 compensation in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments. (E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a 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. (F) 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.
Policy to include benefits for child health supervision services from moment of birth until age nine **See definitions in ORC 3923.01 and 3923.011** **Also see Preventive Services section under the Federal Form Review**	ORC 3923.55	(A) As used in this section and section 3923.56 of the Revised Code: (1) "Child health supervision services" means periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with section 3701.505 of the Revised Code. (2) "Periodic review" means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. (3) "Physician" means a person authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. (B) Notwithstanding section 3901.71 of the Revised Code, each policy of individual or group sickness and accident insurance delivered, issued for delivery, or renewed in this state on or after the effective

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Requirements Checklist		date of this amendment, that provides coverage for family members of the insured shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine. (C) A policy that provides the benefits described in division (B) of this section may limit the benefits to cover only the expenses of child health supervision services that are performed by one physician or by a health care professional under the supervision of one physician during the course of any one visit. (D) Copayments and deductibles shall be reasonable and shall not be a barrier to the necessary utilization of child health supervision services by covered persons. (E) Benefits for child health supervision services that are provided to a child during the period from birth to age one shall not exceed a maximum limit of five hundred dollars, including benefits for the hearing screening required by the program established under section 3701.504 of the Revised Code. The benefits for the hearing screening shall not exceed a maximum limit of seventy-five dollars. Benefits for child health supervision services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred fifty dollars per year.
Prescription drug limitations or exclusions **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.60 (A)(B)(C)	(A) Notwithstanding section 3901.71 of the Revised Code, no group or individual policy of sickness and accident insurance 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. (B) Medical literature may be accepted for purposes of division (A) of this section only if all of the following apply: (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; (2) No article from a major peer-reviewed professional medical journal has concluded, based on

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		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; (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. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature. (C) Coverage of a drug required by division (A) of this section includes medically necessary services associated with the administration of the drug.
Coverage of inpatient care and follow-up for mother and her newborn **See definitions in ORC 3923.01 and 3923.011** **Also see Newborns' and Mothers' coverage section under the Federal Form Review Requirements Checklist**	ORC 3923.63 (A)(B)	(A) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance 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: (1) The policy 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. (2) The policy 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 health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care. 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

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		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 health care professionals responsible for discharging the mother or newborn. (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.
Coverage for emergency services **See definitions in ORC 3923.01 and 3923.011** **Also see Emergency Services section under the Federal Form Review Requirements Checklist**	ORC 3923.65	(A) As used in this section: (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 average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (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; (b) Serious impairment to bodily functions; (c) Serious dysfunction of any bodily organ or part. (2) "Emergency services" means the following: (a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition; (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. (B) Every individual or group policy of sickness and accident insurance that provides hospital,

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		surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services. (C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy shall provide information regarding the following: (1) The scope of coverage for emergency services; (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; (3) Any copayments for emergency services.
Coverage for routine patient care in eligible cancer clinical trial **See definitions in ORC 3923.01 and 3923.011** **Also see Clinical Trials section under the Federal Form Review Requirements Checklist**	ORC 3923.80	(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. (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. (C) As used in this section: (1) "Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria: (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

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		(b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes. (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology. (d) The trial does one of the following: (i) Tests how to administer a health care service, item, or drug for the treatment of cancer; (ii) Tests responses to a health care service, item, or drug for the treatment of cancer; (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; (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer. (e) The trial is approved by one of the following entities: (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services; (ii) The United States food and drug administration; (iii) The United States department of defense; (iv) The United States department of veterans' affairs. (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. (3) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code. (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

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		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. (5) For purposes of this section, a health benefit plan or public employee benefit plan may exclude coverage for any of the following: (a) A health care service, item, or drug that is the subject of the cancer clinical trial; (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; (c) An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration; (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; (e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; (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.
Covered person's payments not to exceed insurer payments **See definitions in ORC 3923.01 and 3923.011**	ORC 3923.81	(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,

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		or multiple employer welfare arrangement has no applicable negotiated reimbursement rate. (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. (C) As used in this section: (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. (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. (3) "Savings account" includes health savings accounts, health reimbursement arrangements, flexible savings accounts, medical savings accounts, and similar accounts and arrangements.
Health care benefit plans covered by chapter – exceptions **See definitions in ORC 3924.01**	ORC 3924.02 (B)	(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.
Health care benefit plans covering small employers subject to conditions – pre-existing, creditable coverage	ORC 3924.03 (A)	(A)(1) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months, or eighteen months in the case of a late enrollee, following the individual's enrollment date and may only relate to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six months immediately preceding the enrollment date. Division (A)(1) of this section is subject to the exceptions set forth in section 2701(d) of the "Health

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See definitions in ORC 3924.01 **Also see Pre-Existing section of the Federal Form Review Requirements Checklist**		Insurance Portability and Accountability Act of 1996." (2) The period of any such pre-existing condition exclusion shall be reduced by the aggregate of the periods of creditable coverage, if any, applicable to the employee or dependent as of the enrollment date. (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. (4) As used in division (A) of this section: (a) "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996." (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.
Health care benefit plans covering small employers subject to conditions – guaranteed renewable **See definitions in ORC 3924.01** **Also see Guaranteed Renewable sections of the Federal Form Review Requirements Checklist**	ORC 3924.03 (B)	(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.

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Health care benefit plans covering small employers subject to conditions – contributions, special enrollment **See definitions in ORC 3924.01** **Also see Special Enrollment section of the Federal Form Review Requirements Checklist**	ORC 3924.03 (E)	(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. 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. 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. (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 shall not be greater than ninety days. (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." (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.
Overcharges	ORC 3924.21	(A) As used in this section: (1) "Beneficiary," "hospital," and "third-party payer" have the same meanings as in section 3901.38

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		of the Revised Code. (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. (3) "Provider" has the same meaning as in section 3902.11 of the Revised Code. (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. (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.
Plan benefits for adopted children	ORC 3924.51	(A) As used in this section: (1) "Child" means, in connection with any adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption. (2) "Health insurer" has the same meaning as in section 3924.41 of the Revised Code. (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. (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.

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		(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.
Coverage for person in custody or confined in jail	ORC 3924.53	(A) As used in this section: (1) "Beneficiary" and "benefits contract" have the same meanings as in section 3901.38 of the Revised Code. (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. (3) "Law enforcement officer" has the same meaning as in section 2901.01 of the Revised Code. (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. (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 **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (D)(2)	(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: "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."

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Coordination of benefits - Appendix A language required **See definitions in OAC 3901-8-01 (C)**	OAC 3901-8-01 (D)(3)(4)	(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. (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.
Provider discount disclosure	OAC 3901-8-02	(A) Purpose This rule sets the requirements that third party payers shall follow if the third party payer receives any discount from billed charges from a health care provider. (B) Authority This rule is issued pursuant to the authority vested in the superintendent of insurance under section 3901.041 of the Revised Code, general rule making authority; and sections 3901.19 to 3901.22 of the Revised Code, the unfair and deceptive acts statute. (C) Definitions (1) "Discount" means any negotiated reduction or variation from the schedule of billed charges (including capitation) that a health care provider otherwise would require a patient and/or the patient's third party payer to pay to that health care provider. (2) "Billed charges" means the non-discounted schedule of charges for services that the health care provider would use to invoice a patient for services rendered. (3) "Third party payer" means any of the following: (a) An insurance company; (b) A preferred provider organization; (c) A labor organization;

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		(d) An employer; (e) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code; (f) A multiple employer welfare arrangement subject to sections 1739.01 to 1739.99 of the Revised Code. (g) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services to beneficiaries under such contract, except that "third party payer" does not include a health insuring corporation licensed pursuant to Chapter 1751 of the Revised Code. (4) "Reasonable cash value" means the amount the third party payer would reimburse the patient or health care provider in the absence of a capitation agreement. (D) Prohibited activity No third party payer that has a negotiated discount with a health care provider, shall do the following: (1) Fail to disclose the existence of such discount to any policy holder, certificate holder, subscriber or enrollee who has purchased health care coverage from the third party payer. Such disclosure shall be contained in the body of the insurance contract, and the certificate if the contract is a group insurance program. Only disclosure of the existence of such discount is required, disclosure of the extent of the discount is not required. (2) Fail to calculate any annual or lifetime maximums only on the basis of actual payments made to non-capitated health care providers. For capitated health care providers the reasonable cash value of the services provided shall be used to calculate annual or lifetime maximums. (3) Fail to maintain adequate records of the compliance with this rule.
Notice regarding policies or certificates	OAC 3901-8-08 (S)(5)(a)	(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)

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which are not Medicare supplement policies.		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: "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."
Complaint Procedure **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**	OAC 3901-8-11 (H)	(H) Complaint procedure Every third-party payer shall: (1) Establish and maintain a procedure for the expeditious resolution of electronic written, and oral complaints initiated by beneficiaries and providers. (2) Include the third party payer's complaint procedure in every benefit plan contract or certificate. (3) Keep records of written complaints from and responses to beneficiaries and providers for three years. (4) Include the following statement or a substantially similar statement on all notification of claim denials: "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." (5) Include the following statement on the written notice to the beneficiary and the provider of the company's final adjudication of a complaint: "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

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		medical practitioner. Submit your request in writing to (insert address of third-party payer). 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."