Ohio Revised Code

Section 1751.11 Evidence of coverage.

Effective: September 29, 2013
Legislation: House Bill 59 - 130th General Assembly

(A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided.

(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.

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(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;

(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;

(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.

(f) The method utilized by the health insuring corporation for resolving enrollee complaints;

(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.

(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:

(a) The enrollee's discharge from the hospital;

(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.

(c) The enrollee's reaching the limit for contractual benefits;

(d) The effective date of any new coverage.

(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;

(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.

(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:

(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.

(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.