Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

10(A) Non-Grandfathered
Individual Major Medical & Dental

This checklist must be submitted with any form filings for Individual Major Medical or Individual Dental plans that are not Grandfathered. This checklist should also be used for Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation. This checklist should not be used for HMO plans.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Product Type: ☐ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☐ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

Contents

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.		
IC 27-8-5-1(c)	**TEMPLATES:** Complete the data templates available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html		
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	document is applicable to the product being filed.		
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. P*lease acknowledge.*		
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-8-5-3(a)(1)	**ENTIRE CONTRACT: CHANGES**: This policy, including the endorsement and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	change this policy or to waive any of its provisions.		
IC 27-8-5-3(a)(2)	**TIME LIMIT ON CERTAIN DEFENSES**: After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant on the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.		
IC 27-8-5-3(a)(3)	**GRACE PERIOD**: A grace period of "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall remain in force. For On-Exchange (Marketplace) products, see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.		
IC 27-8-5-3(a)(4)	**REINSTATEMENT**: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the Insurer or by any agent authorized by the Insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy (see code for remainder of language).		
IC 27-8-5-3(a)(5)	**NOTICE OF CLAIM**: Written notice of claim must be given to the Insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the Insurer, or to any authorized agent of the Insurer, with information sufficient to identify the insured, shall be deemed notice to the Insurer. (See Ind. Code Sec. 27-8-5- 3(a)(5) for alternative language for loss-of-time benefit policies.)		
IC 27-8-5-3(a)(6)	**CLAIM FORMS**: The Insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.		
IC 27-8-5-3(a)(7)	**PROOF OF LOSS**: Written proof of loss must be furnished to the Insurer at its office within 90 days after the date of such loss (within 90 days after termination of Insurer's liability period in case of policy providing periodic payments.) Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year after the time proof is otherwise required.		
IC 27-8-5-3(a)(8) IC 27-8-5.7	**TIME OF PAYMENT OF CLAIMS**: Payment for any loss (other than loss for which the policy provides periodic payment) will be paid immediately upon receipt of due written proof of loss, OR an insurer shall pay or deny each clean claim or notify the claimant of any deficiencies within 30 days if the claim is filed electronically or within 45 days if the claim is filed on paper, whichever is more favorable to the policyholder. If a policy provides for a periodic payment, it will not be paid less frequently than monthly. Any balance remaining unpaid upon the termination of liability when the policy provides periodic payment will be paid immediately upon receipt of due written proof.		
IC 27-8-5-3(a)(9)	**PAYMENT OF CLAIMS**: Indemnity for loss of life will be paid in accordance with the beneficiary designation and the provisions respecting such payment that may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, such indemnity will be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-3(a)(10)	**PHYSICAL EXAMINATIONS AND AUTOPSY**: The Insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.		
IC 27-8-5-3(a)(11)	**LEGAL ACTIONS**: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.		
IC 27-8-5-3(a)(12)	**CHANGE OF BENEFICIARY**: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary, or to any other change in this policy.		
IC 27-8-5-22	**REFUND OF PREMIUM AT DEATH**: Pro-rated from date following date of death to end of paid period.		
IC 27-8-28 IC 27-8-29	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.		
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance		
C. Optional Provisions	**The following provisions are not required in an individual policy. However, if a policy issued or delivered in Indiana addresses the matters listed below, its provisions must appear as stated, preceded by the captions or other approved captions. Any variance in this language must be at least as favorable to the insured and MUST be approved by the Department of Insurance.**		
IC 27-8-5-3(b)(2)	**MISSTATEMENT OF AGE**: If the age of the insured has been misstated, the amounts payable shall be such as the premium paid would have purchased at the correct age.		
IC 27-8-5-3(b)(3)	**OTHER INSURANCE WITH THIS**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	INSURER: If the insured currently has more than one policy with this Insurer, with total benefits exceeding the maximum limit of the policy, then the excess insurance is void and the premium for the excess insurance shall be returned. (Alternatively, only one policy elected by the insured shall be effective, and the Insurer will return any premium for other policies.)		
IC 27-8-5-3(b)(4) IC 27-8-5-3(b)(5)	**INSURANCE WITH OTHER INSURER(S)**: If there is other valid coverage for the same loss, on a provision of service basis or on an expense incurred basis, and this Insurer has not been given notice of the other coverage prior to the loss, the liability of this Insurer will be adjusted as well as a portion of the premiums paid.		
IC 27-8-5-3(b)(7)	**UNPAID PREMIUM**: Any premium due and unpaid upon the payment of a claim under the policy may be deducted from the claim.		
IC 27-8-5-3(b)(8)	**CONFORMITY WITH STATE STATUTES**: Any provision of this policy which, on its effective date, conflicts with the statutes of Indiana (or the state where the insured resides on such date) is hereby amended to conform to the minimum requirements of such statutes.		
IC 27-8-5-3(b)(9)	**ILLEGAL OCCUPATION**: Insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which the contributing cause was the insured's being engaged in an illegal occupation.		
IC 27-8-5-3(b)(10)	**INTOXICANTS AND NARCOTICS**: Insurer shall not be liable for a loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless taken on the advice of a physician. **(Note: to be excluded, the loss must be in consequence of the insured's being intoxicated, not just occurring while the insured is intoxicated or under the influence of narcotics.)** The policy provision under this subdivision may not be used with respect to a policy that provides coverage for hospital, medical, or surgical expenses.		

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D. Individual A&H Policies *Must Provide*			
IC 27-8-5-2(a)(3) IC 27-8-5-28 Bulletin 189	**DEPENDENTS TO AGE 26:** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-8-5-2	**INTELLECTUALLY DISABLED CHILDREN:** If a policy provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age as specified in the policy, it must also provide that a child's attainment of a limiting age does not terminate the hospital and medical coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental, intellectual, or physical disability; and (b) chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer within thirty-one (31) days of the child's attainment of the limiting age.		
IC 27-8-5-15.6	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-8-5-20	**FREE LOOK PERIOD**		
IC 27-8-5-21	**ADOPTED CHILDREN**		
IC 27-8-5-26	**BREAST RECONSTRUCTION & PROSTHESIS** following mastectomy—regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-8-5.6-2(b)	**NEWBORNS**		
IC 27-8-6-4(b)	**REIMBURSEMENT FOR SERVICES**		
IC 27-8-14.5	**DIABETES TREATMENT**, supplies, equipment & education		
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**		
IC 27-8-24-4	**INFANT SCREENING TESTS** required by IC 16-41-17-2 & Minimum maternity stays		
IC 27-8-24.1-5	**INHERITED METABOLIC DISEASE**		
IC 27-8-24.2-5	**ORTHOTIC AND PROSTHETIC DEVICES**		
IC 27-8-24.3	**VICTIMS OF ABUSE** without regard to the abuse		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-26	Individuals without regard to **GENETIC TESTING**		
Bulletin 172	**CHEMOTHERAPY PARITY**		
760 IAC 1-39-7	**AIDS, HIV** and related conditions		
IC 27-8-25	**CLINICAL TRIALS-**Coverage for individuals participating in approved clinical trials: PHSA §2709		
IC 27-8-5-30(h)	**PHARMACY STEP THERAPY EXCEPTION** Company must provide in writing a procedure for use in requesting an exception to a step therapy protocol that includes instructions for making the request and outlines the obligations of the carrier in making the determination and notification of the insured.		
IC 27-8-34	**TELEMEDICINE** services means health care services delivered by use of interactive audio, video, or other electronic media, including (a) medical exams and consultations; and (b) behavioral health, including substance abuse evaluations and treatment. A policy must provide coverage for telemedicine at parity with the same clinical criteria as provided for the same health care services delivered in person. Coverage for telemedicine services may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance that applies to the same health care services delivered in person. Any annual or lifetime dollar limit that applies to telemedicine services must be the same as such dollar limits that applies in the aggregate to all items and services covered under the policy.		
E. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1 and 27-8-5-1.5, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will also be reviewed.**		
IC 27-8-5-1.5(l)(2)	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. Questions inquiring if an applicant has had		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	signs or symptoms of a condition are not permitted.		
IC 27-8-5-1.5(l)(2)	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-8-5-1.5(l)(2)	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be re-filed to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-8-5-1.5(l)(2)	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		
IC 27-8-5-1.5(l)(2)	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		
IC 27-8-5-1.5(l)(2)	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-2.5 IC 27-8-5-1.2(l)(2)	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
F. Individual A&H Policies *Must Cover*	**Due to the EHB Benchmark requirements, the following benefits must be covered.**		
IC 27-8-14.2-4 Bulletin 136 Bulletin 179 IC 27-8-5-1(c)	**AUTISM SPECTRUM DISORDER (PREVIOUSLY PDD)** As per Bulletins 136 and 179, "Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan." Autism Spectrum Disorders include Asperger's Syndrome and Autism.		
IC 27-13-7-15.3 IC 27-8-5-1(c)	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)		
IC 27-13-7-16 IC 27-8-14.8 IC 27-8-5-1(c)	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk) Due to the EHB Benchmark requirements, prostate cancer screening must be covered		
IC 27-13-7-17 IC 27-8-5-1(c)	**COLORECTAL CANCER SCREENING** Due to the EHB Benchmark requirements, colorectal cancer screening must be covered		
G. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302		
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302		
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. Combined with Rehabilitation Services PT-20 visits OT-20 visits ST-20 visits ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please acknowledge* PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please acknowledge*		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	PHSA §2728 45 CFR §147.145		
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please acknowledge* 45 CFR §156.122(a)		
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please acknowledge* PHSA §2715		
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(e)		
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(a)		
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b)		
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b) 45 CFR §155.410		
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR § 147.104(b)		
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	(1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.104(c)		
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	Please acknowledge 45 CFR §147.104(d)		
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(a)		
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge*		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	45 CFR §147.106(c)		
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(d)		
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions:		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	(1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		
H. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330		
I. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, <u>either on or off the Exchange</u>. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is relying on this certification in making its determination whether to approve or disapprove

this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature:_____

Printed Name:_____

Title: _____

Company: _____

Date: _____