Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

20(C) Out of State Association and/or Trust Products Accident & Health

Major Medical certificates and related forms issued to Indiana residents when the policy is issued in a state other than Indiana.

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

Company Name: _____ NAIC #: _____

Form Number(s): _____ Filing Date: _____

To be used with (check all that apply):

- ☐ Small Group
- ☐ Large Group
- ☐ Association
- ☐ Trust
- ☐ Multiple Employer Group
- ☐ Non-Employer Group

Product Type:

- ☐ Major Medical
- ☐ Accident Only
- ☐ Dental
- ☐ Vision
- ☐ Disability Income
- ☐ Specified Disease
- ☐ Short Term Medical
- ☐ Indemnity Only
- ☐ Supplemental Plan
- ☐ Employer Coverage for Medicare Eligible
- ☐ Other: _____

All coverage items marked with a single asterisk (*) must be OFFERED to non-employer based groups.

Some product types may be exempt from certain filing requirements as marked by a double asterisk **.

For product types intended for Health Exchange participation, complete Checklist 10(A) or 12(A) as appropriate, in addition to this checklist.

Requirements in this checklist include:

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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.		
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 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 these three methods: 1. In SERFF on the General Tab - Filing Description; 2. As a note referring to a Cover Letter If using a Cover Letter or NAIC Transmittal, please attach the document to the Supporting Documentation Tab within SERFF.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	Rate Revisions - If this is a revision of previously filed rates, please provide a detailed list of the proposed changes.		
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. *Please acknowledge.*		
B. Required Provisions	**The policy or the certificate contains provisions that are substantially similar to the provisions required by:**		
IC 27-8-5-19(c)(1)	**GRACE PERIOD**: The policyholder has a grace period of 31 days for payment of premium due, except the first premium. Policy remains in force during the grace period, but Insurer may hold claims incurred during grace period until premium is received.		
IC 27-8-5-19(c)(2)	**INCONTESTABILITY:** Validity of policy may not be contested after 2 years except for a) nonpayment of premiums, or if b) the disputed statement is in a written instrument signed by insured. Ineligibility of insured or enrollee under the policy may be disputed any time.		
IC 27-8-5-19(c)(3)	**COPY OF APPLICATION:** If there is an application, a copy must be attached to the policy at issue. Statements made by persons insured are representations, not warranties, and must be provided to insured persons in case of a dispute.		
IC 27-8-5-19(c)(4)	**EVIDENCE OF INSURABILITY**: Insurers may reserve the right to require individual evidence of insurability as a condition of coverage.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-19(c)(5)	**PRE-EXISTING CONDITION LIMITATIONS**: For policies other than those described in section IC 27-8-5-2.5(a)(1) through 2.5(a)(8), any additional exclusions or limitations for a disease or physical condition that existed before the effective date, a) may apply only if advice or treatment was received during 6 months before effective date and b) may not apply to a loss or disability beginning after 12 months or 18 months if a late enrollee.		
IC 27-8-5-19(c)(6)	**PRE-EXISTING CONDITION LIMITATIONS**: For policies described in IC 27-8-5-2.5(a)(1) through 2.5(a)(8), any additional exclusions or limitations for a disease or physical condition that existed before the effective date, a) may apply only if advice or treatment was received during 365 days before effective date and b) may not apply to a loss or disability beginning after the earlier of: 1) 365 days after effective date of coverage which no medical advice or treatment or 2) 2 years after coverage began.		
IC 27-8-5-2.5 Non-employer groups	**PRE-EXISTING CONDITION LIMITATIONS:** 12 months, but credit must be given for previous small group creditable coverage. 12-month look-back. No permanent waivers.		
IC 27-8-5-19(c)(7)	**MISSTATEMENT OF AGE**: Clear statement of how premiums, benefits or both will be fairly adjusted if covered person's age is misstated and if premiums and benefits vary by age.		
IC 27-8-5-19(c)(8)	**CERTIFICATE**: Insurer must issue to policyholder, for delivery to each insured person, a certificate of coverage explaining the protection, to whom the benefits are payable, and each family member and dependent's coverage. (See below for debtor's certificate.)		
IC 27-8-5-19(c)(9)	**TIMELY NOTICE OF CLAIM**: Insured must provide written notice of claim within 20 days after occurrence or commencement of loss, or as soon as reasonably possible.		
IC 27-8-5-19(c)(10)	**CLAIM FORMS**: Insurer must provide forms for filing proof of loss within 15 days of notice of claim, or claimants can submit their own.		
IC 27-8-5-19(c)(11)	**PROOF OF LOSS**: a) For disability claim, written proof of loss must be provided within 90 days of commencement of Insurer's liability and at reasonable intervals thereafter if required. b) For other loss, written proof must be furnished within 90 days of loss. c) Claim will not be reduced if (a) or (b) was not reasonably possible but no later than one (1) year after requirement.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-19(c)(12) 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 27-8-5-19(c)(13)	**BENEFICIARIES**: Loss of life benefits are paid to the beneficiary designated by the insured. If the policy contains conditions pertaining to family status the policy terms apply. All other benefits payable to the person insured. Insurer may also choose to pay up to $5000 to a relative by blood or marriage if beneficiary is an estate or a minor. (Does not apply to policies insuring lives of debtors.)		
IC 27-8-5-19(c)(14)	**PHYSICAL EXAMINATION AND AUTOPSY**: Insurer has the right to examine the person during the pendency of a claim or to conduct an autopsy in case of death, unless prohibited by law.		
IC 27-8-5-19(c)(15)	**LEGAL ACTIONS**: No lawsuit may be filed to recover under the policy before 60 days after proof of loss is filed, and not later than 3 years after proof of loss is required to be filed.		
IC 27-8-5-19(c)(16)	**DEBTOR'S CERTIFICATE**: If policy insures debtors, the Insurer will furnish to policyholder a certificate of insurance for each debtor insured, describing the coverage and benefits payable first to reduce or extinguish indebtedness.		
IC 27-8-10-5.1	**INTELLECTUALLY DISABLED CHILDREN:** An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not terminate a dependent unmarried child's coverage while the dependent is and continues to be both (a) incapable of self-sustaining employment by reason		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	of a mental, intellectual, or physical disability; and (b) chiefly dependent upon the person in whose name the contract is issued for support and maintenance. Proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.		
IC 27-8-5-19(c)(18)	**GUARANTEED RENEWABILITY**: Indiana requires the portability and guaranteed renewability provisions of HIPAA, P.L.104-191.		
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance.		
C. Policies Must Provide ***Key:*** ** = must be offered to non-employer based groups* ***and*** ***=product type may be exempt from certain filing requirements*			
IC 27-8-5-16.5(d)(3)(B)(i)**	**Mental Health Parity**: consistent with IC 27-8-5-15.6 Effective January 1, 2014, major medical 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 services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits.		
IC 27-8-5-16.5(d)(3)(A)(ii)	**Waiver of coverage:** consistent with IC 27-8-5-19.2		
IC 27-8-5-16.5(d)(3)(A)(iii)	**Adopted children:** consistent with IC 27-8-5-21		
IC 27-8-5-16.5(d)(3)(A)(iv)**	**Newborn**, unless pregnancy pre-existed issuance of policy: consistent with IC 27-8-5.6		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-28 Bulletin 189	**Dependent 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 27-8-5-16.5(d)(3)(B)(ii)	**Reissue** following cancellation or nonrenewal: consistent with IC 27-8-5-24		
IC 27-8-5-16.5(d)(3)(B)(iii)	**Breast reconstruction & prosthesis** IF mastectomy is covered: consistent with IC 27-8-5-26		
IC 27-8-5-16.5(d)(3)(B)(iv)	**Non-discriminatory:** consistent with IC 27-8-6		
IC 27-8-5-16.5(d)(3)(B)(v)**	**Mammography/Breast Cancer Screening**: consistent with IC 27-8-14 * Mammography (Baseline, then 1 per year after 40 unless high risk) Due to the EHB Benchmark requirements, mammography **must** be covered in the individual market. IC 27-8-5-1(c)		
IC 27-8-5-16.5(d)(3)(B)(vi)**	**Surgical treatment of Morbid Obesity:** consistent with IC 27-8-14.1 *		
IC 27-8-5-16.5(d)(3)(B)(vii)**	**Diabetes:** consistent with IC 27-8-14.5		
IC 27-8-5-16.5(d)(3)(B)(viii)**	**Prostate cancer screening:** consistent with IC 27-8-14.7 * Prostate cancer screening (1 per year after 50 unless high risk) Due to the EHB Benchmark requirements,		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	prostate cancer screening **must** be covered in the individual market. IC 27-8-5-1(c)		
IC 27-8-5-16.5(d)(3)(B)(ix)**	**Colorectal cancer screening:** consistent with IC 27-8-14.8 * Colorectal cancer screening (1 per year after 50 unless high risk) Due to the EHB Benchmark requirements, colorectal cancer screening **must** be covered in the individual market. IC 27-8-5-1(c)		
IC 27-8-5-16.5(d)(3)(B)(x)	**Off-label drugs:** consistent with IC 27-8-20		
IC 27-8-5-16.5(d)(3)(B)(xi)	**Medical Child Support:** consistent with IC 27-8-23		
IC 27-8-5-16.5(d)(3)(B)(xii)	**Victims of abuse without regard to abuse:** consistent with IC 27-8-24.3		
IC 27-8-5-16.5(d)(3)(B)(xiii)	**Genetic testing:** consistent with IC 27-8-26		
IC 27-8-5-16.5(d)(3)(B)(xiv)	**Internal grievances procedures:** consistent with IC 27-8-28		
IC 27-8-5-16.5(d)(3)(B)(xv)	**External grievance procedures:** consistent with IC 27-8-29		
IC 27-8-5-16.5(d)(3)(B)(xvi)	**Coordination of Benefits:** consistent with 760 IAC 1-38.1		
Bulletin 172	**Chemotherapy parity**		
IC 27-8-5-16.5(d)(3)(B)(xvii)	**AIDS, HIV related conditions** IF other diseases are covered: consistent with 760 IAC 1-39		
IC 27-13-1-34/IC 27-13-7-22	**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 group contract must provide coverage for telemedicine services at parity with the same clinical criteria as provided for the same health care services delivered in person. Coverage for telemedicine services may		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee 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 annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the group contract.		
IC 27-8-5-30(h) IC 27-13-7-23(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 enrollee or insured.		
D. General Regulatory Issues **Under the authority provided by IC 27-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.**			
IC 27-8-5-1.5(l)	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.		
IC 27-8-5-1.5(i)	**ARBITRATION:** Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**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 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1.5(l)	**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 refiled 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)	**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)	**PRIVACY OF HEALTH INFORMATION:** Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.		
IC 27-8-5-1.5(l)	**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.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		
760 IAC 1-8	**NONCANCELLABLE/GUARANTEED RENEWABLE:** Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading.		
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.		
E. ACA Must Provide			
IC 27-8-5-1(c) 45 C.F.R. 147.104(b)	**OPEN ENROLLMENT:** Insurer must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. Insurer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules defined in the Affordable Care Act and pursuant to applicable state law. If the plan is offered in SHOP, coverage must be effective consistent with the dates mandated by the SHOP Exchange even if plan is off Exchange. Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.104(b)	**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 30 calendar days after the date of the qualifying event, described in this section, to elect coverage. Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.104(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan (ii) Within the service area of the plan, deny coverage to employers 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 groups because of its obligations to existing group contract holders. (B) It is applying this section uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees, and dependents. (2) An Insurer that denies health insurance coverage to an employer in any service area		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	may not offer coverage in the group market within the service area to any employer 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 requirements. Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.104(d)	**APPLICATION OF FINANCIAL CAPACITY LIMITS**: Insurer is aware that it may deny health insurance coverage in the group market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies group health insurance coverage to any employer in Indiana under the financial capacity limitations, it may not offer coverage in the group 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 major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(a)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the group market in Indiana it must renew or continue in force the coverage at the option of the plan sponsor subject to exclusions allowed by the Affordable Care Act. Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(b)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may nonrenew or discontinue health insurance coverage offered in the group 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		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	(5) Enrollees' movement outside service area (6) Association membership ceases Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(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 major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(d)	**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 major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(e)	**UNIFORM MODIFICATION OF COVERAGE:** Insurer may only modify coverage at the time of coverage renewal. Applicable for major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.106(f)	**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.		
IC 27-8-5-1(c) 45 C.F.R. 156.122(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 small group major medical plans with effective dates on or after January 1, 2014.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES**		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION**		
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE**		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT**		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS**		
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.		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES**		
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Preventive services also include those covered under PPACA. For a complete listing of preventive services required, see website: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** For Qualified Health Plans (on Exchange) an Insurer must indicate if Pediatric dental services are being excluded from essential health benefits in lieu of Pediatric Stand-Alone qualified dental plan on the Exchange.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	For major medical plans not participating on the Exchange, pediatric dental must be included in the essential health benefits. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange.		
IC 27-8-5-1(c) 45 C.F.R. 156.115(d)	**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.		
IC 27-8-5-1(c) 45 C.F.R. 156.122(a)	**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).		
IC 27-8-5-1(c) 45 C.F.R. 156.130(g) 147.138(b)(3)(i)	**EMERGENCY DEPARTMENT SERVICES:** Emergency department services are provided without imposing any requirement under the plan for prior authorization of services. Additionally, there is no limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network. Applicable for plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 147.150(c)	**CHILD ONLY PLANS:** The Insurer that offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, offers coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21. Applicable for plans with effective dates on or after January 1, 2014. Applicable in the individual and small group markets.		

F. General Regulatory Issues	Under the authority provided by IC 27-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.		
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.		
IC 27-8-5-1(c) 45 C.F.R. 147.104(e)	**MARKETING:** Insurer and its officials, employees, agents and representatives 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 major medical plans with effective dates on or after January 1, 2014.		
IC 27-8-5-1(c) 45 C.F.R. 156.125	**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 small group major medical plans with effective dates on or after January 1, 2014.		

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: _____