

IC 27-8-5

Chapter 5. Accident and Sickness Insurance—Policy Provisions

IC 27-8-5-0.1

Application of certain amendments to chapter

Sec. 0.1. The following amendments to this chapter apply as follows:

- (1) The amendments made to section 1 of this chapter by P.L.257-1985 apply to insurance policies issued after December 31, 1985.
- (2) The amendments made to section 21 of this chapter by P.L.98-1990 apply to a policy issued for delivery in Indiana after June 30, 1990.
- (3) The addition of section 23 of this chapter by P.L.152-1990 applies to a statute or rule mandating the offering of health care coverage enacted or adopted after December 31, 1990.
- (4) The amendments made to section 23 of this chapter by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.
- (5) The addition of section 2.5 of this chapter by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1997.
- (6) The addition of section 2.6 of this chapter (before its repeal) by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1995.
- (7) The amendments made to sections 3 and 19 of this chapter by P.L.91-1998 apply to all accident and sickness policies in force on April 1, 1998.
- (8) The amendments made to section 26 of this chapter by P.L.204-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
- (9) The amendments made to section 15.6 of this chapter by P.L.226-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
- (10) The amendments made to section 2.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.
- (11) The amendments made to section 16.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.
- (12) The amendments made to section 19 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or

renewed after June 30, 2006.

(13) The amendments made to section 3 of this chapter by P.L.98-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after December 31, 2007.

(14) The amendments made to section 2 of this chapter by P.L.218-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(15) The addition of section 28 of this chapter by P.L.218-2007 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

As added by P.L.220-2011, SEC.435.

IC 27-8-5-1

Policy of accident and sickness insurance; filing; review; conformity with federal act

Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this chapter. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) This chapter shall be applied in conformity with the requirements of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), as in effect on September 23, 2010.

(d) A policy of accident and sickness insurance that is issued or delivered through a health benefit exchange established under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), is subject to the requirements of this chapter. The commissioner may adopt rules under IC 4-22-2 to implement this subsection, including rules concerning:

(1) certification or decertification of a qualified health plan (as defined in IC 27-19-2-16); and

(2) open enrollment.
(Formerly: Acts 1953, c.15, s.169.1; Acts 1975, P.L.281, SEC.1.) As amended by P.L.257-1985, SEC.1; P.L.7-1987, SEC.154; P.L.173-2007, SEC.21; P.L.160-2011, SEC.17; P.L.278-2013, SEC.23.

IC 27-8-5-1.5

Filing, review, approval, and disapproval process

Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

(b) As used in this section, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(c) As used in this section, "grossly inadequate filing" means a policy form filing:

- (1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or
- (2) that demonstrates an insufficient understanding of applicable legal requirements.

(d) As used in this section, "policy form" means a policy, a contract, a certificate, a rider, an endorsement, an evidence of coverage, or any amendment that is required by law to be filed with the commissioner for approval before use in Indiana.

(e) As used in this section, "type of insurance" refers to a type of coverage listed on the National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix, or a successor document, under the heading "Continuing Care Retirement Communities", "Health", "Long Term Care", or "Medicare Supplement".

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the performance of the person's duties.

(g) A policy form, including a policy form of a policy, contract, certificate, rider, endorsement, evidence of coverage, or amendment that is issued through a health benefit exchange (as defined in IC 27-19-2-8), may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

- (1) Create a document containing a list of all product filing requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of insurance to which the requirement applies.
- (2) Make the document described in subdivision (1) available on the department of insurance Internet site.
- (3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

- (1) A filer shall submit a policy form filing that:
 - (A) includes a copy of the document described in subsection (h);
 - (B) indicates the location within the policy form or supplement that relates to each requirement contained in the document described in subsection (h); and
 - (C) certifies that the policy form meets all requirements of state law.
- (2) The commissioner shall review a policy form filing and, not more than thirty (30) days after the commissioner receives the filing under subdivision (1):
 - (A) approve the filing; or
 - (B) provide written notice of a determination:
 - (i) that deficiencies exist in the filing; or
 - (ii) that the commissioner disapproves the filing.

A written notice provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h) and must cite the specific requirements not met by the filing. A written notice provided by the commissioner under clause (B)(i) must state the reasons for the commissioner's determination in sufficient detail to enable the filer to bring the policy form into compliance with the requirements not met by the filing.

- (3) A filer may resubmit a policy form that:
 - (A) was determined deficient under subdivision (2) and has been amended to correct the deficiencies; or
 - (B) was disapproved under subdivision (2) and has been revised.

A policy form resubmitted under this subdivision must meet the requirements set forth as described in subdivision (1) and must be resubmitted not more than thirty (30) days after the filer receives the commissioner's written notice of deficiency or disapproval. If a policy form is not resubmitted within thirty (30) days after receipt of the written notice, the commissioner's determination regarding the policy form is final.

- (4) The commissioner shall review a policy form filing resubmitted under subdivision (3) and, not more than thirty (30) days after the commissioner receives the resubmission:
 - (A) approve the resubmitted policy form; or
 - (B) provide written notice that the commissioner disapproves the resubmitted policy form.

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for the commissioner's determination in detail. The commissioner's approval or disapproval of a resubmitted policy form under this subdivision is final, except that the commissioner may allow the filer to resubmit a further revised policy form if the filer, in the filer's resubmission under

subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection (m). A disapproved policy form filing may not be used for a policy of accident and sickness insurance unless the disapproval is overturned in a hearing conducted under this subsection.

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in accordance with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

(j) Except as provided in this subsection, the commissioner may not disapprove a policy form resubmitted under subsection (i)(3) or (i)(4) for a reason other than a reason specified in the original notice of determination under subsection (i)(2)(B). The commissioner may disapprove a resubmitted policy form for a reason other than a reason specified in the original notice of determination under subsection (i)(2) if:

- (1) the filer has introduced a new provision in the resubmission;
- (2) the filer has materially modified a substantive provision of the policy form in the resubmission;
- (3) there has been a change in requirements applying to the policy form; or
- (4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

(k) The commissioner may return a grossly inadequate filing to the filer without triggering a deadline set forth in this section.

(l) The commissioner may disapprove a policy form if:

- (1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or
- (2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

(m) Upon disapproval of a filing under this section, the commissioner shall provide written notice to the filer or insurer of the right to a hearing within twenty (20) days of a request for a hearing.

(n) Unless a policy form approved under this chapter contains a material error or omission, the commissioner may not:

- (1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

As added by P.L.173-2007, SEC.22. Amended by P.L.111-2008, SEC.3; P.L.278-2013, SEC.24.

IC 27-8-5-2

Requirements for issuance and delivery of policy

Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy must insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children who are less than twenty-six (26) years of age, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or

reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to 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 retardation or mental 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 by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a child who has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

- (1) inform the insured that the insured may request the policy in paper form; and
- (2) issue the policy in paper form upon the request of the insured.

(Formerly: Acts 1953, c.15, s.169.2; Acts 1969, c.266, s.1; Acts 1973, P.L.275, SEC.3.) As amended by Acts 1977, P.L.2, SEC.79; P.L.23-1993, SEC.153; P.L.207-1999, SEC.3 and P.L.233-1999, SEC.9; P.L.125-2005, SEC.2; P.L.99-2007, SEC.192; P.L.218-2007,

SEC.45; P.L.160-2011, SEC.18.

IC 27-8-5-2.5

Coverage under individual, and certain association group, policies of accident and sickness insurance; waivers

Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

- (1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Automobile medical payment insurance.
- (4) A specified disease policy.
- (5) A short term insurance plan that:
 - (A) may not be renewed; and
 - (B) has a duration of not more than six (6) months.
- (6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
 - (A) hospital confinement, critical illness, or intensive care; or
 - (B) gaps for deductibles or copayments.
- (7) Worker's compensation or similar insurance.
- (8) A student health plan.
- (9) A supplemental plan that always pays in addition to other coverage.
- (10) An employer sponsored health benefit plan that is:
 - (A) provided to individuals who are eligible for Medicare; and
 - (B) not marketed as, or held out to be, a Medicare supplement policy.

(b) The benefits provided by:

- (1) an individual policy of accident and sickness insurance; or
- (2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;

may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

- (1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of the plan;
- (2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of the plan; or
- (3) a pregnancy existing on the effective date of the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

As added by P.L.93-1995, SEC.6. Amended by P.L.190-1996, SEC.1; P.L.211-2003, SEC.2; P.L.127-2006, SEC.1; P.L.173-2007, SEC.23; P.L.3-2008, SEC.212.

IC 27-8-5-2.6

Repealed

(Repealed by P.L.1-2001, SEC.51.)

IC 27-8-5-2.7

Individual policy of accident and sickness insurance; waiver of coverage

Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter and any other law, and except as provided in subsection (b), an individual policy of accident and sickness insurance that is issued after June 30, 2005, may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

- (1) the waiver period does not exceed ten (10) years; and
- (2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The:

- (i) offer of coverage; and
- (ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.

(C) The:

- (i) offer of coverage; and
- (ii) policy;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance

association under IC 27-8-10.

(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(b) An individual policy of accident and sickness insurance may not include a waiver of coverage for a:

- (1) mental health condition; or
- (2) developmental disability.

(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition or complication that is not specified as required in the:

- (1) written notice under subsection (a)(2)(A); and
- (2) offer of coverage and policy under subsection (a)(2)(B).

(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(e) Upon the expiration of the waiver period allowed under this section, the insurer shall:

- (1) remove the waiver;
- (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
- (3) renew the policy in accordance with 45 CFR 148.122.

As added by P.L.211-2005, SEC.1.

IC 27-8-5-3

Required provisions; statutory option provisions; inapplicable or inconsistent provisions; order of provisions; third party ownership; requirements of other jurisdictions; filing procedure

Sec. 3. (a) Except as provided in subsection (c), each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one (1) or more of the provisions corresponding provisions of different wording approved by the commissioner that are in each instance no less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the 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 insurance producer has authority to change this policy or to waive any of its provisions.

(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (A) After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in 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 (2) year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy of denial of a claim during such initial two (2) year period, nor to limit the application of subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

(1) until at least age fifty (50); or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue;

may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE": After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(B) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "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 continue in force.

A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: "Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a

provision of the policy, in an endorsement on the policy, or in a rider attached to the policy, that subject to the right to terminate the policy upon non-payment of premium when due, such right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.

(4) A provision as follows: 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. Provided, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

- (1) until at least fifty (50) years of age; or
- (2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty (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 at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, the insured shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insurer's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.

(6) A provision as follows: 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 fifteen (15) days after the giving of 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.

(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. 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 one (1) year from the time proof is otherwise required.

(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid:

(1) immediately upon receipt of due written proof of such loss;

or

(2) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. This provision must reflect compliance with IC 27-8-5.7.

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such

designation or provision is then effective, such indemnity shall 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.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$ _____ (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

For the purposes of this section a "minor" is a person under the age of eighteen (18) years. A person eighteen (18) years of age or over is competent, insofar as the person's age is concerned, to sign a valid release.

(10) A provision as follows: **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.

(11) A provision as follows: **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (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 three (3) years after the time written proof of loss is required to be furnished.

(12) A provision as follows: **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 beneficiaries, or to any other changes in this policy.

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(13) A provision as follows: **GUARANTEED RENEWABILITY:** In compliance with the federal Health Insurance Portability and

Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.

(b) Except as provided in subsection (c), no policy delivered or issued for delivery to any person in Indiana shall contain provisions respecting the matters set forth below unless the provisions are in the words in which the provisions appear in this section. However, the insurer may use, instead of any provision, a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any substitute provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of \$ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision:

Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows: **INSURANCE WITH OTHER INSURER:** If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(5) A provision as follows: **INSURANCE WITH OTHER INSURERS:** If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such

proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(6) A provision as follows: RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars (\$200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

- (1) until at least fifty (50) years of age; or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows: CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(9) A provision as follows: ILLEGAL OCCUPATION: The 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 a contributing cause was the insured's being engaged in an illegal occupation.

(10) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

The policy provision under this subdivision may not be used with respect to a policy that provides coverage for hospital, medical, or surgical expenses.

(c) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) The provisions which are the subject of subsections (a) and (b), or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the

policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(e) "Insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(f)(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than is provided in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(f)(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) The commissioner may make reasonable rules under IC 4-22-2 concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper, or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

(Formerly: Acts 1953, c.15, s.169.3; Acts 1971, P.L.392, SEC.1; Acts 1973, P.L.275, SEC.4; Acts 1974, P.L.1, SEC.13.) As amended by P.L.28-1988, SEC.104; P.L.93-1995, SEC.8; P.L.91-1998, SEC.10; P.L.162-2001, SEC.2; P.L.178-2003, SEC.60; P.L.98-2007, SEC.1.

IC 27-8-5-4

Effect of other policy provisions or policy conflicting with chapter

Sec. 4. (a) No policy provision which is not subject to section 3 of this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(b) A policy delivered or issued for delivery to any person in this state in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this chapter.

(Formerly: Acts 1953, c.15, s.169.4.) As amended by P.L.252-1985, SEC.303.

IC 27-8-5-5

Application; attaching copy to policy; furnishing copy to insured; alterations; effect of false statements

Sec. 5. (a) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the

beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(b) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(c) The falsity of any statement in the application for any policy covered by this chapter may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(Formerly: Acts 1953, c.15, s.169.5.) As amended by P.L.252-1985, SEC.304.

IC 27-8-5-6

Defenses of insurer; acts not constituting waiver

Sec. 6. The acknowledgment by any insurer of the receipt of notice given under any policy covered by this chapter, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(Formerly: Acts 1953, c.15, s.169.6.) As amended by P.L.252-1985, SEC.305.

IC 27-8-5-7

Acceptance of premium for period beyond termination date; effect; misstatement of age

Sec. 7. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(Formerly: Acts 1953, c.15, s.169.7.)

IC 27-8-5-8

Exemption of accident and sickness coverage incidental to designated other forms of insurance

Sec. 8. Except as otherwise expressly indicated in this section, nothing contained in sections 1 through 7 of this chapter shall apply to or affect:

- (1) any policy of worker's compensation insurance or any policy of liability insurance with or without supplementary coverage in the policy;
- (2) any policy or contract of reinsurance;
- (3) as to sections 2 through 7 of this chapter, any blanket or group policy of insurance;
- (4) life insurance, endowment, or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as:
 - (A) provide additional benefits in case of death or dismemberment or loss of sight by accident; or
 - (B) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract;
- (5) as to sections 2 through 5 of this chapter, any policies of accident and sickness insurance issued on the industrial plan with premiums payable on a weekly basis; or
- (6) transportation ticket policies sold only at public transportation stations or at public transportation ticket offices by public transportation employees, as to such of the required provisions set out in section 3 of this chapter as are incongruous with the coverage and conditions of the policies.

(Formerly: Acts 1953, c.15, s.169.8; Acts 1955, c.129, s.1.) As amended by P.L.252-1985, SEC.306; P.L.28-1988, SEC.105.

IC 27-8-5-9

Exemption of certain individual policies

Sec. 9. An individual accident and sickness insurance policy form or any form of rider or endorsement appertaining to such a policy form, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before February 20, 1953, may be used or delivered or issued for delivery to any such person at any time prior to January 1, 1956, without being subject to the provisions of sections 2, 3, and 4 of this chapter.

(Formerly: Acts 1953, c.15, s.169.9.) As amended by P.L.252-1985, SEC.307.

IC 27-8-5-10

Repealed

(Repealed by P.L.257-1985, SEC.6.)

IC 27-8-5-11

Franchise plan; accident and sickness insurance; definitions, limitations, requirements, and standards

Sec. 11. No policy of accident and sickness insurance on a franchise plan shall be delivered or issued for delivery to any person in this state unless it conforms to the definitions, limitations, requirements and standards in this section prescribed:

(A) Qualified Groups.

(1) Two (2) or more employees of any employer, inclusive of any governmental division, department or agency.

(2) Ten (10) or more members of any trade, occupational or professional association or of a labor union, or of any other association or group which has had an active existence for at least two (2) years and which has a constitution or by-laws and was formed in good faith for purposes other than that of obtaining insurance.

(3) Members of the family and dependents of persons eligible under (1) or (2) above may be included in the group with such eligible persons.

(B) Nature of Insurance Coverage. The insurance policies issued to members of a qualified group shall be written on identical individual policy form or forms, varying only as to amounts and kinds of coverage applied for by such persons, and such policy form or forms shall otherwise fulfill the requirements of sections 2 through 9 of this chapter. The premiums for such policies may be paid to the insurer periodically by the employer, with or without payroll deduction, or by the association for its members, or by some designated person acting on behalf of such employer or association.

(C) Rates, Benefits, Underwriting Procedures. Premium rates, benefits and underwriting procedures relating to such individual policies may differ from those relating to comparable individual policies issued singly, but as between comparable groups such rates, benefits and procedures shall be nondiscriminatory.

(Formerly: Acts 1953, c.15, s.169.11.) As amended by Acts 1981, P.L.248, SEC.1.

IC 27-8-5-12

Supplementary character of chapter

Sec. 12. This chapter while independent in its enactment of any other statute, is nevertheless a supplement to IC 27-1 and shall be so considered and construed. Accordingly, all general provisions of IC 27-1 shall be fully and completely applicable to the sections of this chapter in the same manner as though such sections were part of IC 27-1.

(Formerly: Acts 1953, c.15, s.169.12.) As amended by P.L.252-1985, SEC.308.

IC 27-8-5-13

Repeal of 1935 act

Sec. 13. Acts 1935, c.162, s.174 is hereby expressly repealed except as to policies issued before February 20, 1953, and except as

to policies which under section 9 of this chapter continue to be issued under said section 174 prior to January 1, 1956.

(Formerly: Acts 1953, c.15, s.169.13.) As amended by P.L.252-1985, SEC.309.

IC 27-8-5-14

Exception of fraternal benefit associations

Sec. 14. The provisions of sections 2 and 3 of this chapter shall not be applicable to fraternal benefit associations or societies.

(Formerly: Acts 1953, c.15, s.169.15; Acts 1957, c.20, s.1.) As amended by P.L.252-1985, SEC.310.

IC 27-8-5-15

Blanket accident and sickness insurance; qualification of groups; policy provisions; payment of benefits

Sec. 15. (a) No policy of blanket accident and sickness insurance shall be delivered or issued for delivery in this state unless it conforms to the requirements of this section.

(1) A policy may be issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation.

(2) A policy may be issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) A policy may be issued to a college, school, or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal, or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

(4) A policy may be issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder.

(5) A policy may be issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors.

(6) A policy may be issued to any volunteer fire department, first aid, emergency management, or other such volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(7) A policy may be issued to a newspaper or other publisher,

which shall be deemed the policyholder, covering its carriers.

(8) A policy may be issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(9) A policy may be issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

(b) Each such policy shall contain in substance provisions which in the opinion of the commissioner are not less favorable to the policyholder and the individual insured than the following:

(1) A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in absence of fraud, be deemed a misrepresentation and not a warranty, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his beneficiary, or assignee, shall have the right to make written request to the insurer for a copy of such application and the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable:

(A) immediately upon receipt of due written proof of such loss; or

(B) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the injured or sick individual when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

The insurer may omit from a policy any portion of any of the above provisions which is not applicable to that policy. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

(c) All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to the insured's designated beneficiary or beneficiaries, or to the insured's estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to the insured's parent, guardian, or other person actually supporting the insured. However, the policy may provide in substance that all or any portion of any benefits provided by any such policy on account of hospital,

nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but, the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligations with respect to the amount of insurance so paid.

(d) This section applies only to policies delivered or issued for delivery in Indiana after August 19, 1975.

(Formerly: Acts 1975, P.L.281, SEC.2.) As amended by P.L.5-1988, SEC.146; P.L.21-1991, SEC.24; P.L.162-2001, SEC.3.

IC 27-8-5-15.5

Inpatient services for treatment of mental illness or substance abuse

Sec. 15.5. (a) As used in this section:

"Alcohol abuse" has the meaning set forth in IC 12-7-2-10.

"Community mental health center" has the meaning set forth in IC 12-7-2-38 and IC 12-7-2-39.

"Division of mental health and addiction" refers to the division created under IC 12-21-1-1.

"Drug abuse" has the meaning set forth in IC 12-7-2-72.

"Inpatient services" means services that require the beneficiary of the services to remain overnight in the facility in which the services are offered.

"Mental illness" has the meaning set forth in IC 12-7-2-130(1).

"Psychiatric hospital" has the meaning set forth in IC 12-7-2-151.

"State department of health" refers to the department established under IC 16-19-1-1.

"Substance abuse" means drug abuse or alcohol abuse.

(b) An insurance policy that provides coverage for inpatient services for the treatment of:

- (1) mental illness;
- (2) substance abuse; or
- (3) both mental illness and substance abuse;

may not exclude coverage for inpatient services for the treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the state department of health or the division of mental health and addiction to offer those services.

As added by P.L.258-1985, SEC.1. Amended by P.L.2-1992, SEC.784; P.L.2-1993, SEC.150; P.L.215-2001, SEC.104.

IC 27-8-5-15.6

Treatment limitations or financial requirements on coverage of services for mental illness

Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical

dependency.

(b) This section applies to a policy of accident and sickness insurance that:

- (1) is issued on an individual basis or a group basis;
- (2) is issued, entered into, or renewed after December 31, 1999; and
- (3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

- (1) A legal business entity that has obtained an exemption under section 15.7 of this chapter.
- (2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
- (3) Coverage issued as a supplement to liability insurance.
- (4) Worker's compensation or similar insurance.
- (5) Automobile medical payment insurance.
- (6) A specified disease policy.
- (7) A short term insurance plan that:
 - (A) may not be renewed; and
 - (B) has a duration of not more than six (6) months.
- (8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
 - (A) hospital confinement, critical illness, or intensive care; or
 - (B) gaps for deductibles or copayments.
- (9) A supplemental plan that always pays in addition to other coverage.
- (10) A student health plan.
- (11) An employer sponsored health benefit plan that is:
 - (A) provided to individuals who are eligible for Medicare; and
 - (B) not marketed as, or held out to be, a Medicare supplement policy.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

As added by P.L.42-1997, SEC.2. Amended by P.L.81-1999, SEC.3; P.L.226-2003, SEC.1; P.L.173-2007, SEC.24.

IC 27-8-5-15.7

Exemption of policies or contracts from laws resulting in certain annual premium increases

Sec. 15.7. (a) The department shall exempt a policy or contract issued by an insurer or health maintenance organization under IC 5-10-8-9, section 15.6 of this chapter, or IC 27-13-7-14.8 by documenting to the department that compliance with the requirements of IC 5-10-8-9(c), section 15.6(d) of this chapter, or IC 27-13-7-14.8(d) have increased the annual premium or rates charged for the policy or health maintenance organization contract by more than four percent (4%) per year. An insurer or a health maintenance organization that applies for an exemption under this section shall provide documentation that is certified by an independent member of the American Academy of Actuaries of actual mental health claims incurred for a period of not less than six (6) months to substantiate the insurer's or health maintenance organization's assertion of increased claims and administrative costs by more than four percent (4%) per year.

(b) Documents submitted under this section must be available for public inspection.

As added by P.L.81-1999, SEC.4.

IC 27-8-5-16

Policy of group accident and sickness insurance; requirements

Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees"

includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the

payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes

retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any

person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

As added by P.L.257-1985, SEC.2. Amended by P.L.19-1986, SEC.47; P.L.125-1992, SEC.1; P.L.8-1993, SEC.429; P.L.185-1996, SEC.11; P.L.218-2007, SEC.46.

IC 27-8-5-16.3

"Small employer"; implementation of program for joint purchase of health insurance; rules

Sec. 16.3. (a) As used in this section, "small employer" has the meaning set forth in IC 27-8-15-14.

(b) The commissioner and the office of the secretary of family and social services may implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in section 16(8) of this chapter.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this section.

As added by P.L.16-2009, SEC.29.

IC 27-8-5-16.5

Conditions for issuance of certificate to resident of Indiana under group policy delivered or issued in another state

Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for

delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter;
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:
 - (i) section 19 of this chapter;
 - (ii) section 21 of this chapter; and
 - (iii) IC 27-8-5.6; and
 - (B) consistent with the requirements set forth in:
 - (i) section 24 of this chapter;
 - (ii) IC 27-8-6;
 - (iii) IC 27-8-14;
 - (iv) IC 27-8-23;
 - (v) 760 IAC 1-38.1; and
 - (vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

- (1) the delivery state has a law substantially similar to section 16 of this chapter;
- (2) the delivery state has approved the group policy; and
- (3) the policy or the certificate contains provisions that are:
 - (A) substantially similar to the provisions required by:
 - (i) section 19 of this chapter or, if the policy or certificate is described in section 2.5(b)(2) of this chapter, section 2.5 of this chapter;
 - (ii) section 19.3 of this chapter if the policy or certificate contains a waiver of coverage;
 - (iii) section 21 of this chapter; and
 - (iv) IC 27-8-5.6; and
 - (B) consistent with the requirements set forth in:
 - (i) section 15.6 of this chapter;
 - (ii) section 24 of this chapter;
 - (iii) section 26 of this chapter;
 - (iv) IC 27-8-6;
 - (v) IC 27-8-14;
 - (vi) IC 27-8-14.1;
 - (vii) IC 27-8-14.5;
 - (viii) IC 27-8-14.7;
 - (ix) IC 27-8-14.8;
 - (x) IC 27-8-20;
 - (xi) IC 27-8-23;

- (xii) IC 27-8-24.3;
- (xiii) IC 27-8-26;
- (xiv) IC 27-8-28;
- (xv) IC 27-8-29;
- (xvi) 760 IAC 1-38.1; and
- (xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.

As added by P.L.185-1996, SEC.12. Amended by P.L.96-2002, SEC.1; P.L.211-2003, SEC.3; P.L.127-2006, SEC.2; P.L.11-2011, SEC.30.

IC 27-8-5-17

Exceptions; discretionary groups; group accident and sickness insurance

Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), 16(7), or 16(8) of this chapter unless:

- (1) the group applies to the commissioner for approval as a discretionary group;
- (2) the commissioner reviews the group according to the same standards as a group described in section 16 of this chapter; and
- (3) the commissioner finds that:
 - (A) the issuance of the policy is not contrary to the best interest of the public;
 - (B) the issuance of the policy would result in economies of acquisition or administration; and
 - (C) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.257-1985, SEC.3. Amended by P.L.268-1987, SEC.2; P.L.125-1992, SEC.2; P.L.185-1996, SEC.13; P.L.218-2007, SEC.47; P.L.11-2011, SEC.31.

IC 27-8-5-18

Extension to family members or dependents; premiums; exclusions; group accident and sickness insurance

Sec. 18. (a) Except for a policy that conforms to the description in section 16(2) of this chapter, a group accident and sickness insurance policy may be extended to insure the employees or members, or any

class or classes of employees or members, with respect to their family members or dependents, subject to subsections (b) and (c).

(b) The premium for the insurance must be paid from funds contributed by the employer, union, association, or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both sources of funds. Except as provided in subsection (c), a policy on which no part of the premium for the coverage of family members or dependents is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and dependent children.

(c) Except as provided in section 24 of this chapter, an insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

As added by P.L.257-1985, SEC.4. Amended by P.L.125-1992, SEC.3.

IC 27-8-5-19

Contents; group accident and sickness insurance

Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

- (1) the provisions described in subsection (c); or
- (2) provisions that, in the opinion of the commissioner, are:
 - (A) more favorable to the persons insured; or
 - (B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement

was made, unless:

- (A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or
- (B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the

effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of

loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) not more than forty-five (45) days after the insurer's (as defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is

a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars (\$5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a child who has mental retardation or a mental or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health

Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

- (1) obtain a certificate described in subsection (c)(8); and
- (2) request the certificate in paper form.

As added by P.L.257-1985, SEC.5. Amended by P.L.165-1986, SEC.1; P.L.23-1993, SEC.154; P.L.185-1996, SEC.14; P.L.91-1998, SEC.11; P.L.207-1999, SEC.4; P.L.233-1999, SEC.10; P.L.14-2000, SEC.58; P.L.162-2001, SEC.4; P.L.125-2005, SEC.3; P.L.127-2006, SEC.3; P.L.99-2007, SEC.193; P.L.173-2007, SEC.25.

IC 27-8-5-19.2

Repealed

(Repealed by P.L.3-2008, SEC.269.)

IC 27-8-5-19.3

Association and discretionary group policies of accident and sickness insurance; waiver of coverage

Sec. 19.3. (a) This section applies to an association or a discretionary group policy of accident and sickness insurance:

- (1) under which a certificate of coverage is issued after June 30, 2005, to an individual member of the association or discretionary group;
- (2) under which a member of the association or discretionary group is individually underwritten; and
- (3) that is not employer based.

(b) Notwithstanding sections 19 and 19.2 of this chapter and any other law, and except as provided in subsection (e), a policy described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

- (1) the waiver period does not exceed ten (10) years; and
- (2) all of the following conditions are met:
 - (A) The insurer provides to the applicant before issuance of the certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The:

- (i) offer of coverage; and
- (ii) certificate of coverage;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition.

(C) The:

- (i) offer of coverage; and
- (ii) certificate of coverage;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and that any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.

(d) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(e) A policy described in subsection (a) may not include a waiver of coverage for a:

- (1) mental health condition; or
- (2) developmental disability.

(f) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition or complication that is not specified as required in the:

- (1) written notice under subsection (b)(2)(A); and
- (2) offer of coverage and certificate of coverage under subsection (b)(2)(B).

(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(h) Upon the expiration of the waiver period allowed under this

section, the insurer shall:

- (1) remove the waiver;
- (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
- (3) renew the policy in accordance with 45 CFR 148.122.

As added by P.L.211-2005, SEC.2.

IC 27-8-5-20

Notice of right to return policy

Sec. 20. (a) All individual accident and health insurance policies, other than those issued pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy:

- (1) except as provided in subdivision (2), within ten (10) days of its delivery; or
- (2) if the policy is a travel accident insurance policy, until the earlier of:
 - (A) thirty (30) days after the policy is delivered; or
 - (B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(b) All accident and health insurance policies issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy:

- (1) except as provided in subdivision (2), within thirty (30) days of its delivery; or
- (2) if the policy is a travel accident insurance policy, until the earlier of:
 - (A) thirty (30) days after the policy is delivered; or
 - (B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(c) Notwithstanding subsection (b), a short term health insurance policy that is written for a period of less than sixty-one (61) days and issued under a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy within ten (10) days after the policy's delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

As added by P.L.267-1987, SEC.5. Amended by P.L.1-1991, SEC.167; P.L.173-2007, SEC.26.

IC 27-8-5-21

Adopted children

Sec. 21. (a) Any individual or group policy or plan of health and accident insurance regulated under this chapter or any health

maintenance organization or limited service health maintenance organization regulated under IC 27-13 that provides coverage under a policy issued for delivery in Indiana must cover newly adopted children of the insured or enrollee. The coverage for newly adopted children will be the same as for other dependents. No policy or plan provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval may be applied to newly adopted children when they are enrolled in accordance with this section.

(b) The coverage required by this section:

(1) is effective upon the earlier of:

(A) the date of placement for the purpose of adoption; or

(B) the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption;

(2) continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; and

(3) continues unless required action as described in subsection

(c) is not taken.

(c) If the payment of a specific premium or subscription fee is required to provide coverage for an adopted child, the policy or contract may require that notification of the adoption of the child as described in subsection (b) and the payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the adoption of the child in order to have the coverage continue beyond the thirty-one (31) day period.

As added by P.L.251-1989, SEC.1. Amended by P.L.98-1990, SEC.2; P.L.26-1994, SEC.11; P.L.116-1994, SEC.59; P.L.2-1995, SEC.106.

IC 27-8-5-22

Refund of unused premiums

Sec. 22. (a) All individual policies of accident and sickness insurance issued for delivery in Indiana after June 30, 1990, must provide for the refund of unused premiums upon the death of the insured during the contract period.

(b) The amount of premium refund shall be prorated from the date following the date of death of the insured to the end of the contract period for which the premium has been paid.

(c) The refund required by this section shall be paid as follows:

(1) If a person other than the insured paid the premium, to that person. A person entitled to a refund under this subdivision must furnish proof of payment to the insurer.

(2) If the insured paid the premium, to the surviving spouse of the insured. If there is no surviving spouse, the premium shall be paid in the same manner as distributions of the net estate of a person who dies intestate under IC 29-1-2-1(d). A parent disqualified under IC 29-1-2-1(e) from receiving an intestate share of the parent's child's estate is not entitled to a refund under this section of insurance premiums paid by the child.

(d) A person entitled to receive a refund under this section must

do the following:

(1) Submit a written request for the refund.

(2) Furnish proof of the insured's death.

(e) This section does not affect the rights of a dependent under a policy covered by this section to obtain a conversion policy upon the death of the insured.

As added by P.L.151-1990, SEC.1. Amended by P.L.101-2008, SEC.4.

IC 27-8-5-23

Statute or rule mandating particular types of health care coverage; applications to insurer

Sec. 23. (a) This section does not apply to IC 27-8-6.

(b) A statute or rule mandating that one (1) or more particular types of health care coverage be provided does not apply to an insurer unless the statute or rule applies equally to employee welfare benefit plans described in 29 U.S.C. 1001 et seq.

As added by P.L.152-1990, SEC.1. Amended by P.L.119-1991, SEC.2.

IC 27-8-5-24

Insured issued new policy within year after cancellation or nonrenewal; mandatory coverage

Sec. 24. If an insurer cancels or declines to renew a group accident and sickness policy for reasons other than fraud or nonpayment of a premium and issues a new policy to the policyholder within one (1) year after the effective date of cancellation of the policy, the insurer must accept for coverage under the new policy an individual who:

(1) was covered under the old policy; and

(2) has continued to meet the requirements for membership in the group that applied to the old policy.

However, the insurer may not exclude or limit the coverage to the individual or individual's dependent due to evidence of insurability.

As added by P.L.125-1992, SEC.4.

IC 27-8-5-25

Maternity benefits; replacement of discontinued policy; prohibition on preexisting condition limitation or exclusion of coverage

Sec. 25. (a) As used in this section, "employer" means an employer who offers health insurance to the employer's employees.

(b) As used in this section, "insurer" means an insurer subject to IC 27.

(c) When an employer that has a group policy issued by an insurer that contains maternity benefits:

(1) discontinues the group health policy provided by the insurer; and

(2) replaces the discontinued policy with coverage through a succeeding insurer;

the succeeding insurer's policy may not contain a preexisting condition limitation for maternity or exclude coverage due to

pregnancy for employees or spouses of employees who were covered under the prior policy on the date the prior plan was discontinued.

(d) Subsection (c) only applies if the employer obtains a new group insurance policy within thirty-one (31) days after the discontinuance of an insurance policy.

As added by P.L.116-1994, SEC.60.

IC 27-8-5-26

Post-mastectomy coverage

Sec. 26. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(b) A policy of accident and sickness insurance that provides coverage for a mastectomy may not be issued, amended, delivered, or renewed in Indiana unless the policy provides coverage as required under 29 U.S.C. 1185b, including coverage for:

- (1) prosthetic devices; and
- (2) reconstructive surgery incident to a mastectomy including:
 - (A) all stages of reconstruction of the breast on which the mastectomy has been performed; and
 - (B) surgery and reconstruction of the other breast to produce symmetry;

in the manner determined by the attending physician and the patient to be appropriate.

(c) Coverage required under this section is subject to:

- (1) the deductible and coinsurance provisions applicable to a mastectomy; and
- (2) all other terms and conditions applicable to other benefits.

(d) An insurer that issues a policy of accident and sickness insurance shall provide to an insured, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the insurer that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.

(e) The coverage required under this section applies to a policy of accident and sickness insurance that provides coverage for a mastectomy, regardless of whether an individual who:

- (1) underwent a mastectomy; and
- (2) is covered under the policy;

was covered under the policy at the time of the mastectomy.

(f) This section does not require an insurer to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.

As added by P.L.150-1997, SEC.3. Amended by P.L.96-2002, SEC.2; P.L.204-2003, SEC.1.

IC 27-8-5-27

Dental care provisions required

Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one

(1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

- (1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Automobile medical payment insurance.
- (4) A specified disease policy.
- (5) A short term insurance plan that:
 - (A) may not be renewed; and
 - (B) has a duration of not more than six (6) months.
- (6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:
 - (A) hospital confinement, critical illness, or intensive care; or
 - (B) gaps for deductibles or copayments.
- (7) Worker's compensation or similar insurance.
- (8) A student health plan.
- (9) A supplemental plan that always pays in addition to other coverage.
- (10) An employer sponsored health benefit plan that is:
 - (A) provided to individuals who are eligible for Medicare; and
 - (B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

- (1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and
- (2) who:
 - (A) has a record of; or
 - (B) is regarded as;having an impairment described in subdivision (1).

(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness

insurance may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).

As added by P.L.189-1999, SEC.2. Amended by P.L.173-2007, SEC.27.

IC 27-8-5-28

Coverage of child to 26 years of age

Sec. 28. 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.

As added by P.L.218-2007, SEC.48. Amended by P.L.160-2011, SEC.19.

IC 27-8-5-29

Health plans offered through health benefit exchange

Sec. 29. (a) The definitions in IC 27-19-2 apply throughout this section.

(b) A health plan may not be offered to any person in Indiana through a health benefit exchange unless:

(1) the form of the policy, classification of risks, and premium rates that apply to the health plan have been filed with and reviewed and approved by the commissioner under this chapter; and

(2) the insurer is authorized under this title to engage in the business of insurance in Indiana.

(c) An insurer that offers a multistate health plan under Section 1334 of PPACA through a health benefit exchange shall file, for review and approval, the form of the policy, classification of risks, and premium rates that apply to the multistate health plan with the commissioner within five (5) business days of the date on which the same filing is made with the federal government.

(d) This title, in conformity with PPACA, applies to a health plan offered through a health benefit exchange to the same extent that this title would apply if the health plan were offered independently of a health benefit exchange.

As added by P.L.278-2013, SEC.25.