IC 27-8
ARTICLE 8. LIFE, ACCIDENT, AND HEALTH

IC 27-8-1
Chapter 1. Life Insurance—Assessment Plan

IC 27-8-1-1
Authority to incorporate
Sec. 1. Any number of persons not less than five (5) nor more than thirteen (13), citizens of the United States, one (1) or more of whom shall be bona fide citizens and voters of this state, may associate themselves together as a body corporate for the purpose of organizing a corporation, association or society to transact the business of life insurance on the assessment plan, subject to the conditions and restrictions hereinafter provided.
(Formerly: Acts 1883, c.136, s.1.)

IC 27-8-1-2
Corporate status and powers
Sec. 2. A corporation, association, or society organized under the provisions of this chapter shall be a body corporate and politic by the name stated in certificate of organization, and by that name, they and their successors:
(1) may have succession, and shall be persons in law capable of suing and being sued;
(2) may have power to make and enforce contracts in relation to the legitimate business of their corporation, association or society;
(3) may have and use a common seal, and may change or alter the same at pleasure, and they or their successors in their corporate name shall in law be capable of taking, purchasing, holding, and disposing of real and personal estate for purposes of their association or society; and
(4) may make bylaws not inconsistent with the constitution and law of this state or the United States, in which bylaws shall be defined the manner and form of electing directors and officers of the corporation, association, or society, and the qualifications and duties of the same, and also the qualifications and privileges of members thereof.
(Formerly: Acts 1883, c.136, s.2.) As amended by P.L.252-1985, SEC.269.

IC 27-8-1-3
Name; approval; misleading similarity
Sec. 3. The corporators shall submit the title or name of the proposed corporation to the auditor of state, who shall approve the same, provided it indicates the object or purpose for which the corporation is formed, and does not too closely resemble a title in use. Before approving a title, it shall be the duty of the auditor of state to examine the titles of corporations appearing in all the
published insurance reports at his command, and not to approve any title that would tend to mislead the public on account of its too closely resembling some other title.

(Formerly: Acts 1883, c.136, s.3.)

IC 27-8-1-4
Statement of initial applications and deposit of first assessment

Sec. 4. Before the charter is granted to any such corporation, it shall file its statement, sworn to by at least two (2) of its executive officers, with the proper state officers, showing that application has been made for not less than two hundred thousand dollars ($200,000) insurance by not less than one hundred (100) persons, and that the amount of the first assessment on each policy or certificate has been deposited in the bank to the credit of the mortuary fund; and it shall be lawful for any corporation, association or society, or its agents, to solicit and secure business to that amount, for the purpose herein provided, before its charter shall have been granted.

(Formerly: Acts 1883, c.136, s.4.)

IC 27-8-1-5
Assessment; statement of object

Sec. 5. Assessment notices sent to members by any such an association shall state the object for which the money to be collected from the insured is intended, and no part of the proceeds of any assessment shall be applied to any other purpose than the stated purpose for which it was collected.

(Formerly: Acts 1883, c.136, s.5.)

IC 27-8-1-6
Exemption of certificates from valuation; insurable interest

Sec. 6. A policy or certificate issued by any such an association shall be exempt from the valuation based upon the American Experience Table, or any other table of mortality, in consequence of such association conducting its business on the plan of assessing members, and such policy or certificate, when the payments thereon are made by any person other than the insured, and without the written consent of the insured, to be valid must be supported by an insurable interest.

(Formerly: Acts 1883, c.136, s.6.)

IC 27-8-1-7
Restriction on kinds of certificates; expenses; segregation of expense and mortuary funds

Sec. 7. No corporation, association, or society organized under the provisions of this chapter shall issue endowment certificates or policies undertaking or promising to pay members during life, except for accident or temporary illness, any stipulated sum of money. The expenses of such corporation, association, or society shall be provided for by admission fees, and either fixed annual payments or assessments made and designated to be for such expenses, and no
part of the expense fund shall in any case be used to pay death claims, and no part of the mortuary fund shall in any case be used to pay expenses.

(Formerly: Acts 1883, c.136, s.7.) As amended by P.L.252-1985, SEC.270.

IC 27-8-1-8
Annual statement; examination

Sec. 8. Any corporation, association, or society carrying on the business of life or accident insurance on the assessment plan shall submit annually, on or before February 28, under oath, to the insurance commissioner a detailed statement of assets, liabilities, insurance in force, and number of persons upon whom risks are in force on the preceding December 31, and answer such interrogatories as the commissioner, who shall furnish a blank for the purpose, may, under the provisions of this chapter make in order to ascertain its financial character and condition, and shall pay to the commissioner, upon filing such statement, a fee of ten dollars ($10), and the commissioner shall publish such statement in his annual report. For the purpose of verifying such statement, the commissioner shall, on petition of a majority of the officers or of ten (10) members of such association supported by the affidavit of one (1) or more of the petitioners showing the necessity therefor, institute an examination of its affairs to ascertain its true character and condition.

(Formerly: Acts 1883, c.136, s.8; Acts 1891, c.189, s.1.) As amended by P.L.252-1985, SEC.271.

IC 27-8-1-9
Repealed

(Repealed by Acts 1978, P.L.2, SEC.2728.)

IC 27-8-1-10
Quo warranto to remove officers or close business

Sec. 10. Whenever any such corporation or association shall fail to make its annual statement to the insurance commissioner before August 31, or if, in the opinion of the commissioner it is conducting its business fraudulently or not in compliance with this chapter or is not carrying out its contract with the members in good faith, then it shall be the duty of the commissioner to communicate the fact to the attorney general, who may thereupon commence proceeding, by writ of quo warranto against such corporation, association, or society, requiring it to show cause why its officers should not be removed or its business closed, and the court shall thereupon hear the allegations and proofs of the respective parties; and if it shall appear to the satisfaction of such court that the officers of such corporation, association, or society, or any one (1) or more of them, have been guilty of any material irregularity or violation of law to the injury of such corporation, association, or society, the said court shall decree a removal from office of the guilty party or parties and substitute suitable persons to serve until the regular annual election, or until a
successor is regularly chosen; or if it shall appear to the court that the interest of the public so requires, the court shall decree a dissolution of such corporation, association, or society and a distribution of its effects.

(Formerly: Acts 1883, c.136, s.10.) As amended by P.L.252-1985, SEC.272.

IC 27-8-1-11
Bonds of officers and agents
Sec. 11. No agent or officer of such corporation, association or society, shall be permitted to collect or receive any dues or assessments for or on account of the same until he executes, jointly with two (2) responsible sureties, a bond to the corporation, approved by the board of directors thereof, in such sum as they shall prescribe, conditioned upon the payment of all dues, assessments or funds over to the proper officer of such corporation, and all receipts of any such corporation shall be paid into the hands of the treasurer thereof, who shall, before assuming the duties of his office, give a bond in the sum of not less than ten thousand dollars ($10,000), with not less than two (2) sureties, to be approved by the board of directors, and conditioned for the faithful performance of his duties, and the accounting for, and the proper payment and disbursement by him of, all moneys thereof which come into his hands.
(Formerly: Acts 1883, c.136, s.11.)

IC 27-8-1-12
Examination of sufficiency of treasurer's bond
Sec. 12. Said bond of treasurer shall be examined as to its efficiency annually by the auditor of state, and it shall then be renewed if he shall deem the present bond insufficient. Said bond shall be recorded in the recorder's office in the county in this state in which one (1) of the incorporators resides, and a certified copy of said record shall, by said recorder, be forwarded to the auditor of state, who shall file and preserve the same in his office.
(Formerly: Acts 1883, c.136, s.12.)

IC 27-8-1-13
Qualification of foreign corporation
Sec. 13. Any corporation, association or society, organized under the laws of any other state or government to insure lives on the assessment plan, or any corporation carrying on the business of life or accident insurance on the assessment plan, shall be licensed by the auditor of state, upon the payment to the auditor of state of a fee of twenty-five dollars ($25.00), to do business in this state. However, the corporation or association shall first deposit with the auditor of state a certified copy of its charter or articles of incorporation, a copy of its statement of business for the preceding year, with the names and residence of its officers, sworn to by the president and secretary, or like officers, showing a detailed account of expenses and income, the amount of insurance in force, its assets and liabilities in detail,
IC 27-8-1-14
Retaliatory provision

Sec. 14. When any other state or government shall impose any obligation upon such corporation, association or society of this state, or their agents transacting business in such other state or government, the like obligations are hereby imposed on similar corporations, associations or societies of such other state or government, and their agents or representatives, transacting business in this state.

(Formerly: Acts 1883, c.136, s.14; Acts 1889, c.169, s.2.)

IC 27-8-1-15
Foreign corporations; annual statement and fee; license revocation for failure to file statement; solvency statement from foreign state

Sec. 15. Such corporation, association or society, shall pay to the auditor of state, upon filing each annual statement, a fee of ten dollars ($10.00). And in the event of its failure to make such statement on or before the thirty-first day of August of each year, the auditor of state shall revoke its license, and thereafter, or until such statement is made, it shall be deemed to be doing business unlawfully in this state. When the auditor of state of this state shall have reason to doubt the solvency of any such foreign corporation, association or society, he shall accept a statement from the insurance commissioner, or like officer of the state under whose authority it was organized, as prima facie evidence of its solvency.

(Formerly: Acts 1883, c.136, s.15.)

IC 27-8-1-16
Foreign corporations; fraudulent practices; quo warranto to revoke license

Sec. 16. When, in the auditor's opinion, such corporation or association is in this state conducting its business fraudulently, or is not carrying out its contracts with members residing in this state, in
good faith, he shall report the same to the attorney-general, who shall thereupon commence proceedings by writ of quo warranto against such corporation or association, requiring it to show cause why its license to do business in this state should not be revoked.
(Formerly: Acts 1883, c.136, s.16.)

**IC 27-8-1-17**
Noncompliance; violations

Sec. 17. An officer, agent, or employee of a corporation or association who knowingly permits the corporation or association to do business in Indiana, unless it has complied with the laws of this state applicable to the same, commits a Class B misdemeanor.

**IC 27-8-1-18**
Exemption of fraternal societies

Sec. 18. The provisions of this chapter shall in no way apply to any secret or fraternal society or lodge or association which, under the supervision of a grand or supreme lodge, secures membership through the lodge system exclusively, and provides insurance to its members, nor to insurance organizations of a purely benevolent character which pay no commission nor employ any paid insurance producer, organized under the laws of this or any other state.
IC 27-8-2
Chapter 2. Assessment Policy—Specified Payment

IC 27-8-2-1
Specification of exact payment upon each contingency insured against

Sec. 1. Every policy or certificate hereafter issued by any insurance corporation of this state doing business on the assessment plan, or any insurance corporation of any other state authorized to do an assessment insurance business in this state, and providing a payment to be made upon a contingency of death, sickness, disability or accident, shall specify the exact sum of money which it promises to pay upon each contingency insured against, and the number of days after satisfactory proof of the happening of such contingency at which such payment shall be made, and upon the occurrence of such contingency, unless the contract shall have been voided for fraud or breach of its conditions, the corporation shall be obligated to the beneficiary for such payment at the time and to the amount specified in the policy or certificate.

(Formerly: Acts 1901, c.214, s.1.)

IC 27-8-2-2
Failure to pay amount specified; proceedings to close business

Sec. 2. Failure to pay the amount, whether in friendly settlement or by judgment of court, within thirty (30) days of its adjudication, shall constitute a forfeiture of the right of the delinquent corporation to further continue in business in this state, in the case of an insurance corporation of another state, and in the case of an insurance corporation of this state, it shall be the duty of the insurance commissioner to report the facts to the attorney general, who shall immediately bring suit to close up the business of the delinquent corporation. Nothing in this chapter shall be construed as affecting any organization doing business under IC 27-11.

(Formerly: Acts 1901, c.214, s.2.) As amended by P.L.252-1985, SEC.274; P.L.3-1990, SEC.98.
IC 27-8-3-1
Authority to incorporate; purposes; articles of incorporation; initial applications; approval and filing documents; license

Sec. 1. Any number of persons not less than five (5), a majority of whom are citizens of this state, may associate themselves together as a corporation, association, or society for the purpose of transacting the business of life or accident, or life and accident insurance, and for the payment of partial and permanent disability claims to living members, upon the assessment plan, for the purpose of mutual protection and relief of its members, and for the payment of stipulated sums of money to the families, heirs, executors, administrators, or assigns of the deceased members, or for the payment of total and permanent disability claims to living members of such company, association, or society, as the member may direct, in such manner as may be provided in the bylaws; and may receive money, either by voluntary donation or contribution, for which purpose, they shall make, sign, and acknowledge, before any officer authorized to take acknowledgment of deeds in this state, articles of incorporation or association, in which shall be stated the name or title by which such corporation, association, or society shall be known in law, the location of its principal business office (which office must be located in this state), the names and residence of the persons signing the articles of incorporation or association, the object of the corporation, association, or society, with its plan of doing business clearly and fully defined, the number of its directors, trustees or managers and the names of those selected to serve until its first annual meeting, and, in case of life corporations, associations, or societies, the limit as to age of applicants for membership, which shall not exceed sixty-five (65) years, and that medical examinations are required, but no medical examination shall be required in case of accident corporations, associations, or societies, and that bona fide applications have been secured for two hundred thousand dollars ($200,000) by not less than two hundred (200) persons, who have each made application for membership in such proposed corporation, association, or society, and, in case of a life corporation, have each been examined and recommended by a reliable physician, and in all cases have each deposited with the parties asking the certificate for such corporation, association, or society the sum of two dollars ($2) on each one thousand dollars ($1,000) of insurance applied for as an advance assessment for mortuary or accident or disability indemnity purposes, as the case may be; which certificate of association and applications, together with the certificate of some solvent bank or banks that all such advance funds are deposited therein to be turned over to the treasurer of such corporation, association, or society when organized, shall be submitted to the insurance commissioner, who shall carefully examine the same, and, if he shall find that the objects and purposes are fully and definitely set forth and are clearly within...
the provisions of this chapter, and that the name or title is not the
same or does not so closely resemble a title in use as to have a
tendency to mislead the public, the commissioner shall submit the
same to the attorney general for examination, and if found by him to
be in accordance with this chapter and not inconsistent with the
constitution and laws of the United States and of this state, he shall
certify to and deliver the same to the secretary of state, who shall
cause the same, with the certificate of the attorney general, to be
recorded in a book to be kept for that purpose; and, upon application
of the signers thereof, the secretary of state shall furnish to them a
certified copy of such articles and certificates, under his hand and the
seal of this state, and the secretary of state shall thereupon file in the
office of the commissioner a certified copy of all papers pertaining to
the organization of such corporation, association, or society.
Thereupon, the commissioner shall issue a license, authorizing said
corporation, association, or society to transact the business set forth
in the certificate of incorporation. Such corporation, association, or
society shall deposit with the commissioner a copy of all its forms of
policy issued by them, together with a copy of its bylaws and all
forms of application for insurance.
(Formerly: Acts 1897, c.195, s.1.) As amended by P.L.252-1985,
SEC.275.

IC 27-8-3-2
Corporate powers
Sec. 2. A corporation, association, or society, organized under the
provisions of this chapter, shall, by the name adopted by such
corporation, association, or society, in law, be capable of suing and
being sued, and may have power to make and enforce contracts in
relation to the business of such corporation, association, or society,
may have and use a common seal and may change or alter the same
at pleasure, and, in the name of the corporation, association, or
society, or by a trustee chosen by their board of directors, shall, in
law, be capable of taking, purchasing, holding, and disposing of real
and personal property for the purposes of their organization, may by
their board of directors, trustees or managers, make bylaws not
inconsistent with the constitution and laws of this state or of the
United States, which bylaws shall define the manner of electing
directors, trustees, or managers, or officers of such corporation,
association, or society, and the qualifications and duties of the same,
with terms of office not exceeding three (3) years, also the
qualifications and privileges of the members thereof.
(Formerly: Acts 1897, c.195, s.2.) As amended by P.L.252-1985,
SEC.276.

IC 27-8-3-3
Directors, trustees, or managers
Sec. 3. The affairs of all corporations, associations, or societies
organized or doing business under the provisions of this chapter shall
be managed by not less than five (5) directors, trustees, or managers,
a majority of whom shall be residents of the state of Indiana, who shall be elected from and by the members, at such time and place and for such period, not exceeding three (3) years, as may be provided for in the bylaws, and may be eligible for reelection, provided that as near as practicable, an equal number shall be elected each year. Whenever directors, trustees, or managers shall be elected, a certificate, under the seal of the corporation, association, or society, giving the names and residences of those elected and the term of their office, shall be filed in the office of the insurance commissioner. Vacancies in the board of directors, trustees, or managers shall be filled in the manner provided in the bylaws. Such board of directors, trustees, or managers shall fix the compensation to be paid to all officers and managers of such corporation, association, or society. *(Formerly: Acts 1897, c.195, s.3.) As amended by P.L.252-1985, SEC.277.*

IC 27-8-3-4
Determination of fee rates and amount of premiums, assessments, or periodical calls; risks

Sec. 4. The trustees, directors, or managers, or the persons designated in the bylaws of the corporation, association, or society, subject to the provisions of this chapter, shall fix the fee rates and amounts of premiums, assessments, or periodical calls, and the time and manner of the payment thereof, and the risks to be assumed by such corporation, association, or society, and the duration thereof, and may change the same, from time to time, as the experience of the corporation, association, or society may require. An affidavit made by the person having charge of the mailing of notices of premiums, assessments, or periodical calls that any such notice was mailed to his last postoffice address, stating the date of mailing, shall be prima facie evidence thereof. *(Formerly: Acts 1897, c.195, s.4.) As amended by P.L.252-1985, SEC.278.*

IC 27-8-3-5
Reincorporation of domestic assessment plan companies; exceptions

Sec. 5. Any domestic corporation, association, or society, transacting business of life or accident or life and accident insurance and providing for the payment of total and permanent disability claims to living members, upon the assessment plan, may be reincorporated or reorganized under the provisions of this chapter under its existing corporate name, by filing with the insurance commissioner a declaration of their desire to do so, signed and duly acknowledged by a majority of its board of directors, trustees, or managers, with a statement in like manner signed and acknowledged by them that such corporation, association, or society, having insured the lives or provided for the payment of accident indemnity, has accumulated the fund required by section 7 of this chapter, or having engaged in the business of accident insurance only, has accumulated
the fund required by section 11 of this chapter, and that such funds are safely invested and held for the purposes for which the same were accumulated, as provided in the bylaws of such corporation, association or society, whereupon the commissioner, if approved by him, shall file the same, together with his certificate of such approval, with the secretary of state, who shall issue to such corporation, association, or society a certificate of such reincorporation or reorganization, under the seal of the state, and attach thereto copies of all papers so filed with the secretary of state, and the same shall be recorded in the office of the secretary of state, and copies thereof filed in the office of the commissioner, and such corporation, association, or society shall thereupon be deemed to be reincorporated and reorganized under the provisions of this chapter.

It shall not be obligatory upon any such existing corporation, association or society to incorporate or reincorporate under this chapter, and any such domestic corporation, association, or society may continue to exercise all the rights, powers, and privileges not inconsistent with this chapter, pursuant to its articles of incorporation or association, the same as if incorporated or reincorporated under this chapter.

(Formerly: Acts 1897, c.195, s.5.) As amended by P.L.252-1985, SEC.279.

IC 27-8-3-6
Application of chapter to assessment plan companies; exceptions

Sec. 6. Any incorporation, association or society organized to insure lives, which provides for the payment of policy claims, or the accumulation of reserve or emergency funds, and the expenses of the management and prosecution of the business by payments to be made either at periods named in the contract or upon assessments as required, by persons holding similar contracts, and wherein the insured's liability to contribute to the payment of policy claims accrued or to accrue is not limited to a fixed sum, shall be deemed to be engaged in the business of life insurance upon the assessment plan, and shall be subject only to the provisions of this chapter. However, nothing contained in this chapter shall be construed as applicable to any association of religious or secret societies, or to any class of mechanics, express, telegraph or railroad employees, or veterans described in IC 10-17-5-2 or IC 10-17-5-1 formed for the mutual benefit of the members thereof and their families exclusively, or to any secret or fraternal societies, lodges or councils that may be organized, or that are now organized and doing business in this state, which conduct their business and secure members on the lodge system exclusively, having ritualistic work and ceremonies in their societies, lodges or councils, and which are under the supervision of the grand or supreme body, nor to any association organized solely for benevolent purposes and not for profit.

IC 27-8-3-7
Accumulation of reserve or emergency fund; investment; additional funds; use of excess

Sec. 7. Every such life insurance corporation, association, or society shall accumulate and maintain a reserve or emergency fund equal to such sum as might be realized from one (1) assessment on, or periodical payment by, policy or certificate holders thereof, and, in no event, less than the amount of its maximum policy or certificate. Such fund, if not already accumulated, shall be accumulated by every such corporation, association, or society existing on March 9, 1897, by September 9, 1897, and by every corporation, association, or society formed under this chapter after March 9, 1897, within six (6) months from the date of its incorporation or organization, and shall be held as a trust fund for the purposes for which such fund was created or accumulated. In case such fund or any portion thereof shall have been used by the corporation, association, or society for the purpose or purposes for which the same was created or accumulated and the amount thereof thereby reduced to less than the amount of one (1) death assessment or periodical payment, the amount of such reduction below the amount of one (1) death assessment or periodical payment shall be made up and restored to said fund within six (6) months thereafter. Such fund may be held in cash or invested in the same class of securities required by law for the investment of funds by insurance corporations; and nothing contained in this chapter shall prevent the creation and accumulation of other funds in excess of the amount required in this chapter to provide for the purposes of such corporation, association, or society. If such fund is in excess of the amount of one (1) death assessment or periodical payment upon all certificate or policyholders and not less than the sum of fifty thousand dollars ($50,000), the excess or any portion thereof may be used in the reduction of assessment or periodical payments by policy or certificate holders by ratable cash dividends or credits, or in such other equitable division or apportionment thereof as its bylaws or rules may provide, and such use shall not be deemed or construed to mean a profit received by members within the meaning of the statutes of this state, or the pro rata excess on any policy or certificate terminated by death or surrender may be refunded to the holder or beneficiary, as may be provided for in said policy or contract; provided, that nothing contained in this chapter shall be construed to permit any contract promising any fixed cash payment to any living certificate or policyholder excepting in the contingency of physical disability.

(Formerly: Acts 1897, c.195, s.7.) As amended by P.L.252-1985, SEC.280.

IC 27-8-3-8
Assignment of policy to person without insurable interest void

Sec. 8. No corporation, association or society doing business of life insurance under this chapter shall issue any policy of life
insurance in which the beneficiary named has no insurable interest. Any assignment of the policy or certificate to a person having no insurable interest in the insured life, except as security for actual debt, with remainder over to the beneficiary or to the estate of the insured, shall render such a policy or certificate void.

(Formerly: Acts 1897, c.195, s.8; Acts 1971, P.L.391, SEC.1.)

IC 27-8-3-9
Annual report; failure to file report and pay fees; suspension from doing business
Sec. 9. Every such life insurance corporation, association, or society doing business under this chapter shall, on or before March 1 in each year, make and file with the insurance commissioner a report of its affairs and operations during the year ending on December 31 immediately preceding, which report shall be in lieu of all other reports required by this title and shall be in such form as the commissioner may require. Such report shall be verified by such of the officers of the corporation, association, or society as the commissioner may require. Any corporation, association, or society refusing or neglecting to make such report, or to make payment of any of the fees required by law, shall, upon the order of the commissioner, cease to do business in this state until such report and payment shall be made and until the costs of such action be paid.

(Formerly: Acts 1897, c.195, s.9.) As amended by P.L.252-1985, SEC.281.

IC 27-8-3-10
Accident insurance business on assessment plan
Sec. 10. Any corporation, association, or society organized to insure against the contingency of death or physical disability of the assured thereunder resulting from accidental injuries, and which provides for the payment of policy claims, the accumulation of reserve or emergency funds and the expenses of the management and prosecution of the business, by payments to be made, either at periods named in the contract or upon assessments as required by persons holding similar contracts, and where the assured's liability to contribute to the payment of benefits accrued or to accrue is not limited to a fixed sum, shall be deemed to be engaged in the business of accident insurance upon the assessment plan, and the business involving the issuance of such contracts shall be carried on in this state only by duly organized and authorized corporations, associations, or societies, which shall be subject only to the provisions and requirements of this chapter.

(Formerly: Acts 1897, c.195, s.10.) As amended by P.L.252-1985, SEC.282.

IC 27-8-3-11
Reserve emergency fund
Sec. 11. Every such accident insurance corporation, association, or society shall accumulate and maintain a reserve emergency fund
of at least two thousand dollars ($2,000). Such fund, if not already accumulated, shall be accumulated by every such corporation, association, or society existing on March 9, 1897, by September 9, 1897, and by every corporation, association, or society organized under this chapter within six (6) months of the completion of its organization and the receipt of its certificate of authority to transact business in this state, and every corporation, association, or society subject to the provisions of this chapter shall add to such emergency fund thereafter two and one-half percent (2 1/2%) of the amount realized from every premium, assessment, or periodical call until such fund shall be equal to the amount of two dollars ($2) for every five thousand dollars ($5,000) of insurance in force. Such emergency fund, or any part thereof, may be used for the payment of death and indemnity claims; provided, that if the amount of such fund be thereby reduced below the amount contemplated in this chapter, the amount by which such fund is reduced be made up and restored within six (6) months thereafter. Such fund may be held in cash or invested in the same class of securities required by law for the investment of funds by insurance corporations, and nothing contained in this chapter shall prevent the creation and accumulation of other funds in excess of the amount required in this chapter to provide for the purposes of such corporation, association, or society.

(Formerly: Acts 1897, c.195, s.11.) As amended by P.L.252-1985, SEC.283.

IC 27-8-3-12
Report of affairs and operations; suspension for failure to file

Sec. 12. (a) Every such accident insurance corporation, association, or society doing business under this chapter shall, on or before March 1 in each year, make and file with the insurance commissioner a report of its affairs and operations during the year ending on December 31 immediately preceding, which report shall be in lieu of all other reports required by this title and shall be verified by such officers of the corporation, association or society, as the commissioner may require, and shall contain answers to the following questions:

1. First, what number of certificates or policies were issued during the year or applicants admitted?
2. Second, what was the amount of death indemnity affected thereby?
3. Third, what number of death losses were incurred?
4. Fourth, what number of death losses were paid and amount thereof?
5. Fifth, what were the total number of indemnity claims paid and amount thereof?
6. Sixth, what were the number of death and number of indemnity claims unpaid?
7. Seventh, does the corporation, association, or society charge annual dues or membership fee? If so, how much?
8. Eighth, what was the total amount received and whether
from assessment, annual dues, membership fees, or other sources, and the disposition thereof?

(9) Ninth, does corporation, association, or society use moneys received for payment of claims to pay expenses, in whole or in part? And, if so, state the amount used.

(10) Tenth, what is the amount of the emergency fund and how invested?

(11) Eleventh, if organized under the laws of this state, state such fact and the date of organization.

(12) Twelfth, what were the number of policies in force and death insurance in force at the beginning of the year, and such other information as may be required by the superintendent of insurance?

(b) Any corporation, association, or society refusing or neglecting to make such report or to make payment of any one of the fees required by this chapter shall, upon the order of the insurance commissioner, cease to do business in this state until such report and payment shall be made and until the costs of such action be paid.

(Formerly: Acts 1897, c.195, s.12.) As amended by P.L.252-1985, SEC.284.

IC 27-8-3-13
Authority to deposit securities; investment of reserve funds

Sec. 13. This chapter shall not be construed to limit the accumulation of a reserve or emergency fund by any corporation, association, or society subject to the provisions of this chapter. Any such corporation, association, or society may, in its discretion, through its officers or directors, deposit with the insurance commissioner such securities and for such amounts as may be approved by him, and, when so deposited, shall be retained by him for the purposes described in this chapter. All other investments of reserve funds shall be made in the same class of securities as are allowed by law for the investment of funds by insurance corporations.


IC 27-8-3-14
Specification of amount payable upon particular contingency; obligation for payment; suspension of right to issue new policies until payment made

Sec. 14. Every policy or certificate issued after March 9, 1897, by any corporation, association, or society doing business under this chapter and promising payment to be made upon a contingency of death or physical disability shall specify the sum of money which it promises to pay under such contingency, and the number of days after satisfactory proof of the happening thereof on which such payment shall be made. Upon the occurrence of such contingency, unless the contract shall have been avoided by fraud, or by breach of its conditions, the corporation, association, or society shall be
obligated to the beneficiary for such payment, at the time and to the amount specified in the policy or certificate. If such corporation, association, or society shall refuse or fail to make such payment for sixty (60) days after final judgment has been obtained against such claim, the insurance commissioner shall notify the corporation, association, or society not to issue any new policies or certificates until such indebtedness is fully paid; and no officer or agent of the corporation, association, or society shall make, sign, or issue any policy or certificate of insurance while such notice is in force.

(Formerly: Acts 1897, c.195, s.14.) As amended by P.L.252-1985, SEC.286.

IC 27-8-3-15
Transfer or reinsurance of risks; approval; notice of preference for transfer to different corporation

Sec. 15. No such corporation, association or society, organized under the laws of this state, shall transfer its risks to, or reinsure them in any other corporation, association or society unless the contract of transfer or reinsurance is first submitted to and approved by a two-thirds (2/3) vote of a meeting of the insured, called to consider the same, of which meeting, a written or printed notice shall be mailed to each member, certificate or policyholder, at least thirty (30) days before the day fixed for such meeting. If such transfer or reinsurance shall be approved, every member, certificate or policyholder of the corporation, association or society, who shall file with the secretary thereof, within ten (10) days after the meeting, a written notice of his preference to be transferred to some other corporation, association or society, than that named in the contract, shall be accorded all the rights and privileges, if any, in aid of such transfer as would have been accorded under the terms of such contract had he been transferred to the corporation, association or society named therein. No such corporation, association or society, organized under the laws of this state, shall transfer its risks or assets, or any part thereof, to, or reinsure its risks, or any part thereof, in any insurance corporation, association or society of any other state or country which is not at the time of such transfer or reinsurance authorized to do business in this state under the laws thereof.

(Formerly: Acts 1897, c.195, s.15.)

IC 27-8-3-16
Examination at request of corporation; certificate of results; expense

Sec. 16. The insurance commissioner shall, at the request of any corporation, association, or society doing business under the provisions of this chapter in this state on the assessment plan, make an examination of such corporation, association, or society, and shall furnish a certificate of the results of such examination, showing all its assets and how invested, and such other particulars as may be deemed necessary to show the character and condition of said corporation, association, or society, and the necessary expense of said examination.
shall be paid by the corporation, association, or society requesting it.  
(Formerly: Acts 1897, c.195, s.16.) As amended by P.L.252-1985, SEC.287.

IC 27-8-3-17  
Visitation and inspection; insolvency or improper business practices; report; order to show cause for termination of business  
Sec. 17. All corporations, associations, and societies to which this chapter is applicable, with their books, papers, and vouchers, shall be subject to visitation and inspection by the insurance commissioner or such person as he may designate, at the expense of said association. The commissioner may address any inquiries to such corporation, association, or society, in relation to its doings or condition, or any other matter connected with its transactions relative to the business contemplated by this chapter. All officers of such corporation, association, or society shall promptly reply in writing to all such inquiries, under the oath of its president, secretary, or other officers, if required. When the commissioner on investigation, shall be satisfied that any corporation, association, or society, organized under the laws of this state, doing business in this state of the character defined in this chapter, is insolvent because of matured death claims or other obligations due and unpaid, exceeding its assets and death assessments or periodical payments, called or in process of collection, or has exceeded its powers, failed to comply with any provision of law, or is conducting business fraudulently, he shall report the facts to the attorney general, who, if he shall be of the opinion that the facts require such action, may thereupon apply to any court having jurisdiction thereof, within the county in which the principal office of such corporation, association, or society in this state is located, for an order requiring the officers of such corporation, association, or society to show cause, at a reasonable time and place within such county, why such corporation, association, or society should not be restrained from continuing to transact business, with power to the court to adjourn the hearing thereon from time to time, not exceeding sixty (60) days in all.  
(Formerly: Acts 1897, c.195, s.17.) As amended by P.L.252-1985, SEC.288.

IC 27-8-3-18  
Attorney general; exclusive power to apply for accounting, injunction, or receivership  
Sec. 18. No order, judgment, or decree providing for an accounting or enjoining, restraining, or interfering with the prosecution of the business of any domestic insurance corporation, association, or society subject to the provisions of this chapter, or appointing a temporary or permanent receiver thereof, shall be made or granted otherwise than upon the application of the attorney general on his own motion, or after his approval of a request in writing thereof by the insurance commissioner, except in an action by a judgment creditor or in proceedings supplementary to execution.
IC 27-8-3-19
Foreign corporations; requirements for authority to do business; revocation of authority; retaliation clause

Sec. 19. Any corporation, association, or society organized under the authority of another state or government to issue, or which is engaged in the business of issuing, policies or certificates of life or accident or life and accident insurance, and for the payment of total and permanent disability claims to living members on the assessment plan, as a condition precedent to transacting business in this state, shall deposit with the insurance commissioner:

(1) a certified copy of its articles of incorporation or association;
(2) a certified copy of a vote or resolution of the board of directors of said company consenting that service of process in any suit against such company may be served upon an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer, appointed by the company as the company's agent for service of process, with like effect as if such company was chartered, organized, or incorporated in the state of Indiana, and agreeing that any process served upon such agent shall be of the same legal force and validity as if served upon said company, and agreeing that such service may be so made with such effect while any liability remains outstanding against such company in this state;
(3) a statement, under oath of its president and secretary, in the form by the commissioner required, of its business for the preceding year;
(4) a certificate, under oath of its president and secretary, that it is paying, and for the twelve (12) months then next preceding, has paid, the maximum amount named in its policies or certificates in full;
(5) a certificate from the proper authority in its home state that corporations, associations or societies of this state, engaged according to the provisions of this chapter in life or accident, or life and accident insurance, and for the payment of total and permanent disability claims to living members upon the assessment plan, are legally entitled to do business in such state;
(6) a copy of its policy or certificate, application, and bylaws, which must show that the insured's liability to contribute to the payments of benefits is not limited to the payment of a fixed periodical sum; and
(7) evidence satisfactory to the commissioner that the corporation, association, or society accumulates a fund equal in amount to that required of similar corporations, associations, or societies of this state and that such accumulation is permitted by the law of the corporation, association, or society and is for the benefit of policy or certificate-holders only, and is invested in securities authorized under the law of its incorporation or
The insurance commissioner shall thereupon issue or renew the authority of such corporation, association, or society to do business in this state, and such authority shall be revoked whenever the commissioner, on investigation, is satisfied that such corporation, association, or society is not paying the maximum amount named in its policies or certificates in full. Upon such revocation, the commissioner shall cause notice thereof to be published in a newspaper of general circulation, published in the city of Indianapolis, Indiana, and no new business shall be thereafter done by its agents in this state. If any such corporation, association, or society is authorized by the law under which it is incorporated to issue contracts of insurance not contemplated in this chapter, it shall nevertheless be permitted to transact in this state the character of business authorized by this chapter upon complying in all other respects with the requirements thereof and filing with the commissioner an agreement duly executed by the proper officers that such corporation, association, or society will not enter into or issue within this state any contract of insurance, policy, or agreement not authorized by this chapter. Upon a breach of such agreement by any such corporation, association, or society, the commissioner shall forthwith revoke and cancel its authority to transact business in this state. When any other state or country shall impose any obligation upon such corporation, association, or society of this state, the like obligation shall be imposed upon similar corporations, associations, or societies and their agents of such state or country doing business in this state. If the laws of such state where such corporation, association, or society is organized will not admit corporations, associations, or societies organized in this state, or doing business under this chapter, to do business in such state, then such corporations, associations, or societies shall not be admitted to do business in this state.


IC 27-8-3-20
Foreign corporations; service of process
Sec. 20. All processes in any action or proceeding against any foreign corporation, association, or society doing business in this state under the provisions of this chapter may be served upon an individual resident of Indiana, a corporate resident of Indiana, or an authorized Indiana insurer, appointed by the corporation, association, or society as its agent for service of process, and any lawful process against it which is served on the agent shall be of the same legal force and validity as if served on the corporation, association, or society, and this provision shall continue in force so long as any liability remains outstanding against the corporation, association, or society in this state, service upon such agent shall be deemed sufficient service upon the principal. When legal process against any such corporation, association, or society is served upon such agent, the
agent shall immediately notify the corporation, association, or society of such service by registered letter, prepaid, directed to its secretary, or, in case of a corporation, association or society of a foreign country, to the resident manager, if any, in this country, and shall, within two (2) days after such service, forward in the same manner a copy of the process served on the agent to such secretary or manager, or to any person previously designated by the corporation, association, or society, in writing. The agent shall keep a record of all processes served upon the agent which record shall show the day and hour when such service was made.


IC 27-8-3-21
Fraudulent representations; offenses

Sec. 21. A person who knowingly makes a false or fraudulent statement or representation in or with reference to any application for insurance, or for the purpose of obtaining any money or benefit in or to any corporation, association, or society transacting business under this chapter, commits a Class A misdemeanor.

(Formerly: Acts 1897, c.195, s.21.) As amended by Acts 1978, P.L.2, SEC.2726.

IC 27-8-3-22
Eligible beneficiaries; change of beneficiary

Sec. 22. Any member of such corporation, association or society may name as his payee or beneficiary any person or persons, natural or artificial, permitted by the by-laws of such corporations, associations or society, or, if the by-laws thereof permit, the insurance of such member may be made payable to his estate. Any member of such corporation, association or society, naming as his payee or beneficiary any such person or persons, may make such designation either revocable or irrevocable, and the option which he elects to exercise shall be set out in and be made a part of his application for a certificate or policy of insurance. When the right of revocation has been reserved, or in case of the death of any payee or beneficiary under either a revocable or an irrevocable designation, the insured, subject to any existing assignment of the policy, may designate a new payee or beneficiary, with or without reserving the right of revocation, by filing written notice thereof at the home office of the corporation, association or society, accompanied by the policy for suitable endorsement thereon. No person who shall have been designated as a payee or beneficiary by the insured shall have or obtain any vested interest in the death benefits which may accrue in the event of the death of the insured until such death benefits shall have become due and payable upon the death of the insured.

(Formerly: Acts 1897, c.195, s.22; Acts 1923, c.185, s.1.)

IC 27-8-3-23
Exemption of benefits and premiums from judicial process

Sec. 23. (a) As used in this section, "premium" includes any deposit or contribution.

(b) The money or benefit provided or rendered by any corporation, association, or society authorized to do business under this chapter shall not be liable to attachment by garnishee or other process, and shall not be seized, taken, appropriated, or applied by any legal or equitable process, nor by any operation of law, to pay any debt or liability of a policy or certificate holder or any beneficiary named therein.

(c) A premium paid for an individual life insurance policy that names as a beneficiary, or is legally assigned to, a spouse, child, or relative who is dependent upon the policy owner is not exempt from the claims of the creditors of the policy owner if the premium is paid:

   (1) not more than one (1) year before the date of the filing of a voluntary or involuntary bankruptcy petition by; or
   (2) to defraud the creditors of;

the policy owner.

(d) The insurer issuing the policy is discharged from all liability by payment of the proceeds and avails of the policy (as defined in IC 27-1-12-14(b)) in accordance with the terms of the policy unless, before payment, the insurer has received at the insurer's home office, written notice by or on behalf of a creditor of the policy owner that specifies the amount claimed against the policy owner.


IC 27-8-3-24
Violations; revocation of power to do business

Sec. 24. An officer or agent of any corporation, association, or society subject to this chapter who fails to comply with this chapter, knowingly makes in any report or statement any false or fraudulent statement, or refuses to permit the insurance commissioner or any examiner duly authorized by him for the purpose to make examination of its condition and business, books, papers, and vouchers commits a Class C infraction. A person who fails to comply with or violates this chapter commits a Class C infraction. If an examination of the condition and business of any such corporation, association, or society transacting business in this state is prevented by an offense under this section, the insurance commissioner shall revoke the certificate of authority issued to such corporation, association, or society, and it is unlawful for it to do business in this state until it has submitted to an examination, and the insurance commissioner has issued to it a new certificate of authority authorizing it to continue business in this state.

(Formerly: Acts 1897, c.195, s.24.) As amended by Acts 1978, P.L.2, SEC.2727.

IC 27-8-3-25
Fees
Sec. 25. The fees to be paid by each such corporation, association, or society to the insurance commissioner for the authority to such corporation, association, or society, and its insurance producers under the license granted by him to each corporation, association, or society, to transact business in the state of Indiana shall be as follows:

For filing copy of charter or articles of incorporation, twenty-five dollars ($25).
For filing each annual statement, twenty dollars ($20).
For issuing certificate of authority or license to company, corporation, association or society, one dollar ($1).
For issuing license to each insurance producer, one dollar ($1).
For affixing seal and certifying to any paper, one dollar ($1).
For renewal of license, each such corporation, association, or society shall file with the commissioner its annual statement, for which it shall pay the sum of twenty dollars ($20).

For the privilege of transacting business in this state, a foreign or alien company, association, or society, admitted and licensed under this chapter, shall pay an annual tax upon premiums or assessments derived from business written within this state, such tax to be as defined and determined under IC 27-1-18-2, which is declared to be applicable in its terms and provisions to such a company, association, or society; provided also, that when any other state or country shall impose any obligations in excess of those imposed by this chapter upon any such corporation, association, or society of this state, a like obligation shall be imposed on similar corporations and their agents of such state or country doing business in this state; and provided also, that such corporation, association, or society, in transacting business in this state, shall be subject only to the provisions of this chapter.


IC 27-8-3-26
Exempt organizations

Sec. 26. Nothing contained in sections one through twenty-five of this chapter shall be construed to apply to secret or fraternal societies, lodges or councils that are now organized, or that may hereafter be organized, which conduct their business and secure members on the lodge system, exclusively, having ritualistic work and ceremonies in their societies, lodges or councils, and which are under the supervision of a grand or supreme body, nor to any association organized solely for benevolent purposes and not for profit; nor to any association of religious or secret societies, nor to any class of mechanics, express, telegraph or railroad employees or veterans described in IC 10-17-5-2 or IC 10-17-5-1 or any existing societies now doing business and formed for the mutual benefit of the members thereof and their families exclusively.

IC 27-8-3-27
Legal reserves; compulsory deposits; filing of forms; exceptions

Sec. 27. (a) Notwithstanding any of the provisions of sections 1 through 26 of this chapter, every corporation or association organized and operating under the provisions of this chapter shall on or before July 1, 1970, comply with the provisions of IC 27-1 relative to the maintenance of legal reserves required on all life insurance and health and accident insurance policies issued in this state, and relative to compulsory deposit of assets by life insurance companies, and relative to filing of forms, with particular reference to but not limited to IC 27-1-12-11 through IC 27-1-12-13, IC 27-1-12.8, IC 27-1-13-8, and IC 27-1-20-1 through IC 27-1-20-11.

(b) Provided, that this section shall not apply to any corporation or association that has prior to July 1, 1970, reorganized and accepted the provisions of IC 27-1, as provided in IC 27-1-11. Nor shall this section apply to any insurance policies issued or sold prior to July 1, 1970, or prior to any such reorganization under IC 27-1, whichever occurs earlier.

(c) Provided, further, that with respect to insurance policies issued by any corporation or association on a pure assessment basis, no premiums having been collected in advance, which corporation or association is incorporated and operating under this chapter as of August 18, 1969, and which has had in force between August 18, 1964, and August 18, 1969, insurance policies covering not less than fifteen thousand (15,000) members, such company or association shall maintain, beginning January 1, 1971, a legal reserve on its life assessment business on the basis of monthly renewable term insurance, and said monthly unearned premium reserve shall be calculated at one dollar and thirty cents ($1.30) per member.

(d) Such legal reserve shall be deposited with the insurance department under compulsory deposit provisions referred to in subsection (a).

(Formerly: Acts 1897, c.195, s.26a; Acts 1969, c.236, s.1.) As amended by P.L.252-1985, SEC.294; P.L.276-2013, SEC.29.
Chapter 4. Credit Life and Credit Accident and Health Insurance

IC 27-8-4-0.1
Application of certain amendments to chapter
Sec. 0.1. The addition of section 9.5 of this chapter by P.L.226-1993 applies to policies issued after June 30, 1993.
As added by P.L.220-2011, SEC.434.

IC 27-8-4-1
Purpose
Sec. 1. The purpose of this chapter is to promote the public welfare through the establishment of unified and consistent rules relating to the implementation and administration of the laws of this state pertaining to credit life insurance and credit accident and health insurance, as such insurances are defined and limited in this chapter.
(Formerly: Acts 1961, c.47, s.1.) As amended by P.L.252-1985, SEC.295.

IC 27-8-4-2
Citation; scope; definitions
Sec. 2. (a) Citation and Scope:
(1) This chapter may be cited as the Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance.
(2) All life insurance and all accident and health insurance of the nature in this chapter defined in connection with loans or other credit transactions shall be subject to the provisions of this chapter, except such insurance issued in relation to an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

(b) Definitions. For the purpose of this chapter:
(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.
(2) "Credit accident and health insurance" means insurance on a debtor to provide funds for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.
(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights, or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any such lender, vendor, or lessor, and any affiliate, associate, or subsidiary of any of them or any director, officer, or employee of any of them or any other person in any way associated with any of them.
(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction. The
term includes the following:
(A) A joint debtor.
(B) A co-maker.
(C) An endorser.
(D) A guarantor.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(6) "Commissioner" means insurance commissioner of Indiana.

(7) The term "accident and health insurance" has the same meaning as "accident and sickness insurance" sometimes used in other statutes relating to insurance against accident and sickness.


IC 27-8-4-3
Forms of insurance
Sec. 3. Credit life insurance and credit accident and health insurance shall be issued only in the following forms:
A. Individual policies of life insurance issued to debtors on the term plan;
B. Individual policies of accident and health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;
C. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;
D. Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.
(Formerly: Acts 1961, c.47, s.3.)

IC 27-8-4-4
Limitations on amount of insurance
Sec. 4. A. Credit Life Insurance. The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, when an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater. Notwithstanding the provisions of this paragraph, insurance on agriculture credit transaction commitments, not exceeding one (1) year in duration, may be written up to the amount of the loan commitment on a non-decreasing or level term plan.

B. Credit Accident and Health Insurance. The aggregate amount of periodic benefits payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not, in the case of an indebtedness repayable in installments, exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness or
in the case of an indebtedness payable in one sum, the unpaid amount of such indebtedness; and the amount of each periodic benefit payment shall not exceed the original indebtedness divided by the number of periodic installments.

(Formerly: Acts 1961, c.47, s.4.)

IC 27-8-4-5
Term of insurance
Sec. 5. The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. This rule shall apply when no evidence of insurability is required and, as well, when such evidence is required and is furnished within the period of thirty (30) days after the date when the debtor becomes obligated to the creditor; but should such evidence of insurability be furnished after such thirty (30) day period, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 8 of this chapter.

(Formerly: Acts 1961, c.47, s.5.) As amended by P.L.252-1985, SEC.297.

IC 27-8-4-6
Policy or certificate; delivery; rejection of risk; to another insurer; credit for lower premium
Sec. 6. (a) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance or credit accident and health insurance shall, in addition to other requirements of law, set forth:

(1) the name and home office address of the insurer;
(2) the name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor;
(3) the premium or amount of payment, if any, by the debtor
separately for credit life insurance and credit accident and health insurance;
(4) a description of the coverage including the amount and term thereof;
(5) any exceptions, limitations, and restrictions; and
(6) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(c) Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in this chapter.

(d) If said individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth:
   (1) the name and home office address of the insurer;
   (2) the name or names of the debtor;
   (3) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance; and
   (4) the amount, term, and a brief description of the coverage provided;
shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Said application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in section 5 of this chapter.

(e) If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance, if one can be obtained from another insurer, setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.


IC 27-8-4-7
Filing of documents; disapproval of form of policy; effect; withdrawal of approval; review
Sec. 7. (a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the commissioner.

(b) The commissioner shall, within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the coverage, or are contrary to any provision of this title or of a rule promulgated under this title.

(c) If the commissioner notifies the insurer that the form is disapproved, it shall be unlawful thereafter for such insurer to issue or use such form. In such notice, the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement, or rider, shall be issued or used until the expiration of thirty (30) days after it has been so filed, unless the commissioner shall give his prior written approval thereto.

(d) The commissioner may, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in subsection (b). The written notice of such hearing shall state the reason for the proposed withdrawal.

(e) It shall be unlawful for the insurer to issue such forms or use them after the effective date of such withdrawal.

(f) If a group policy of credit life insurance or credit accident and health insurance:

1. has been delivered by an insurer in this state before July 6, 1961; or
2. has been or is delivered by an insurer in another state before or after July 6, 1961;

such insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in sections 6(b) and 6(d) of this chapter, and such forms shall be approved by the commissioner if they conform with the requirements specified in sections 6(b) and 6(d) and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates on file with the commissioner; provided, however, that the premium rate in effect on group policies existing on July 6, 1961, may be continued until the first policy anniversary date following the date this section becomes operative as provided in section 12 of this chapter.

(g) Any order or final determination of the commissioner under the provisions of this section shall be subject to judicial review.
IC 27-8-4-8
Revision of rate schedules; credit or refund of premiums

Sec. 8. A. Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner.

B. Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; Provided, however, That the commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the commissioner.

C. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

D. The amount charged to a debtor for any credit life or credit health and accident insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(Formerly: Acts 1961, c.47, s.8.)

IC 27-8-4-9
Persons authorized to issue or deliver policies

Sec. 9. All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses issued by the commissioner.

(Formerly: Acts 1961, c.47, s.9.)

IC 27-8-4-9.5
Debtor's right to cancel policy; required provisions in application form; time limit

Sec. 9.5. (a) An individual or group policy of credit life insurance or credit accident and health insurance may not be delivered or issued for delivery in Indiana unless the application or authorized form:

(1) provides the debtor with a right to cancel the policy not more than fourteen (14) days after the policy is issued; and

(2) informs the debtor of the right to cancel in plain and conspicuous language.
(b) The language informing the debtor of the right to cancel under subsection (a)(2) must explain the way in which the debtor may cancel the policy and, if applicable, the address to which the debtor may mail the notice of cancellation.

(c) After the debtor cancels a policy under a provision required by subsection (a), the insurer or creditor shall return to the debtor the premium paid by the debtor.


IC 27-8-4-10
Report, adjustment, and settlement of claims

Sec. 10. A. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

B. All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

C. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; Provided, That a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

(Formerly: Acts 1961, c.47, s.10.)

IC 27-8-4-11
Debtor's choice of insurer; use of existing policies

Sec. 11. When life insurance or accident and health insurance is required as additional security for any indebtedness, the debtor shall have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state. As used in this section, "life insurance" and "accident and health insurance" includes any form and any amount of life insurance or accident and health insurance that affords security to the creditor for the indebtedness involved.

(Formerly: Acts 1961, c.47, s.11.)

IC 27-8-4-12
Rules; order for compliance

Sec. 12. The commissioner may, after notice and hearing, issue such rules as he deems appropriate for the supervision of this chapter. Whenever the commissioner finds that there has been a violation of this chapter or any rules issued pursuant to this chapter and after written notice thereof and hearing given to the insurer or other person
authorized or licensed by the commissioner, he shall set forth the
details of his findings together with an order for compliance by a
specified date. Such order shall be binding on the insurer and other
person authorized or licensed by the commissioner on the date
specified unless sooner withdrawn by the commissioner or a stay
thereof has been ordered by a court of competent jurisdiction. The
provisions of sections 5, 6, 7, and 8 of this chapter shall not be
operative until October 4, 1961, and the commissioner in his
discretion may extend until not later than January 2, 1962, the initial
period within which the provisions of sections 5, 6, 7, and 8 shall not
be operative.
(Formerly: Acts 1961, c.47, s.12.) As amended by P.L.252-1985,
SEC.300.

IC 27-8-4-13
Judicial review
Sec. 13. Any party to the proceeding affected by an order of the
commissioner shall be entitled to judicial review under IC 4-21.5-5.
(Formerly: Acts 1961, c.47, s.13.) As amended by P.L.252-1985,
SEC.301; P.L.7-1987, SEC.153.

IC 27-8-4-14
Violations; civil penalty; revocation or suspension of license or
certificate of authority
Sec. 14. In addition to any other penalty provided by law, any
person, firm, or corporation which violates an order of the
commissioner after it has become final, and while such order is in
effect, shall, upon proof thereof to the satisfaction of the court, forfeit
and pay to the state of Indiana a sum not to exceed two hundred fifty
dollars ($250), which may be recovered in a civil action, except that
if such violation is found to be willful, the amount of such penalty
shall be a sum not to exceed one thousand dollars ($1000). The
commissioner, in his discretion, may revoke or suspend the license
or certificate of authority of the person, firm, or corporation guilty of
such violation. Such order for suspension or revocation shall be upon
notice and hearing, and shall be subject to judicial review as provided
in section 13 of this chapter.
(Formerly: Acts 1961, c.47, s.14.) As amended by P.L.252-1985,
SEC.302.
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.
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.


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
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.


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.

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.


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.


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.


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.


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.


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.


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.
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.

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.


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.

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.

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.


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;
then 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

(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.


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:
      (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,

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.


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.


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.


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.


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.


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).


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.


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.
IC 27-8-5.5
Chapter 5.5. Accident and Sickness Insurance—Claim Forms

IC 27-8-5.5-1
Definitions
Sec. 1. As used in this chapter:
(a) "Commissioner" means the insurance commissioner of Indiana.
(b) "Accident and sickness insurance" means any policy or contract of insurance described in classes 1(b), 2(a), 2(b), or 2(l), as defined in IC 27-1-5-1.

IC 27-8-5.5-2
Promulgation of forms; requisites; contents; acceptance of claims; explanation of benefits paid statements or claims summary statements
Sec. 2. (a) The commissioner shall prescribe by rule, after consultation with providers of health care or treatment, accident and sickness insurers, hospital, medical, and dental service corporations and other prepayment organizations, such accident and sickness insurance claim forms as the commissioner determines will provide for uniformity and simplicity in insurance reporting. The forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident or sickness insurance policy or a hospital, medical, or dental service contract.
(b) An accident and sickness insurer may not refuse to accept a claim submitted on duly promulgated uniform claim forms. However, an insurer may accept claims submitted on any other form.
(c) Accident and sickness insurer explanation of benefits paid statements or claims summary statements sent to an insured by the accident and sickness insurer may be sent in electronic or paper form and shall be in a format and written in a manner that promotes understanding by the insured by setting forth:
(1) the total dollar amount submitted to the insurer for payment;
(2) any reduction in the amount paid due to the application of any co-payment or deductible, along with an explanation of the amount of the co-payment or deductible applied under the insured's policy;
(3) any reduction in the amount paid due to the application of any other policy limitation or exclusion as set forth in the insured's policy along with an explanation thereof;
(4) the total dollar amount paid; and
(5) the total dollar amount remaining unpaid.
In addition, the explanation shall clearly set forth a toll free number that the insured may call to obtain additional information about any of the items contained in the explanation of benefits paid or claims summary statement.
(d) The commissioner may issue an order under IC 27-1-3-19(a) directing an accident and sickness insurer to comply with subsection (c).

(e) An accident and sickness insurer does not violate subsection (c) by using a document that the accident and sickness insurer has been required to use by the federal government or the state.

(f) An accident and sickness insurer shall:
    (1) inform an insured that the insured may request that the statements described in subsection (c) be sent in paper form; and
    (2) send the statements in paper form upon the request of the insured.


IC 27-8-5.5-3
Obtaining additional information regarding claims
Sec. 3. The adoption of uniform claim forms by the commissioner pursuant to this chapter does not preclude an insurer, hospital, medical, or dental service corporation or other pre-payment organization, from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage, as may be required.

IC 27-8-5.6
Chapter 5.6. Accident and Sickness Insurance—Coverage for Newborns

IC 27-8-5.6-0.1
Application of certain amendments to chapter
Sec. 0.1. The amendments made to section 2 of this chapter by P.L.189-1997 apply only to a policy or contract of accident and sickness insurance that is issued or renewed after June 30, 1997. As added by P.L.220-2011, SEC.436.

IC 27-8-5.6-1
"Accident and sickness insurance" defined
Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 1971, 27-1-5-1, as governed by IC 1971, 27-8-5.
(b) 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
       (A) may not be renewed; and
       (B) has a duration of not more than six (6) months.
   (7) 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.
   (8) A supplemental plan that always pays in addition to other coverage.
   (9) A student health plan.
   (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.

IC 27-8-5.6-2
Policy provisions
Sec. 2. (a) Except as provided in subsection (b), all individual and group accident and sickness insurance policies or contracts which provide coverage on an expense incurred basis or a provision of service basis for:
(1) an individual insured, certificate holder, or subscriber; or
(2) a family member or child of the insured, certificate holder, or subscriber;
shall, as to such individual or family members' coverage, also provide
that the insurance benefits applicable for the individual or family member shall be payable with respect to a newly born child of the insured, certificate holder, or subscriber from the moment of birth.

(b) Subsection (a) does not require the coverage of a newly born child of an insured or a subscriber under an individual accident and sickness policy or contract if the pregnancy resulting in the birth of the newly born child was a condition that existed prior to the issuance of the policy or contract. If the pregnancy resulting in the birth of a newly born child was a condition that existed prior to the issuance of the policy or contract, coverage for the newly born child under the policy or contract is subject to the underwriting practices followed by the insurer at the time of the birth of the child.

(c) The coverage for newly born children required by subsection (a) shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for newly born children required by subsection (a) shall include but not be limited to benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.


IC 27-8-5.6-3
Payment of specific premium; notification of birth

Sec. 3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and 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 date of birth in order to have the coverage continue beyond the thirty-one (31) day period.

(Formerly: Acts 1975, P.L.282, SEC.1.)

IC 27-8-5.6-4
Application of chapter

Sec. 4. This chapter applies to accident and sickness insurance policies and contracts delivered or issued for delivery in Indiana after October 1, 1975.

As added by P.L.5-1988, SEC.148.
Chapter 5.7. Accident and Sickness Insurance; Provider Payment

"Accident and sickness insurance policy" defined
Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-5-1.

"Clean claim" defined
Sec. 2. As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

"Insurer" defined
Sec. 3. As used in this chapter, "insurer" means an insurance company issued a certificate of authority in Indiana to issue accident and sickness insurance policies. The term includes:
1. a preferred provider plan (as defined in IC 27-8-11-1); and
2. an insurance administrator that:
   A. collects charges or premiums; and
   B. adjusts or settles claims;
in connection with coverage under an accident and sickness insurance policy.

"Provider" defined
Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Notice of deficiencies in claims
Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with section 6 of this chapter.
(b) An insurer shall notify a provider of any deficiencies in a submitted claim not more than:
1. thirty (30) days for a claim that is filed electronically; or
2. forty-five (45) days for a claim that is filed on paper;
and describe any remedy necessary to establish a clean claim.
(c) Failure of an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.
IC 27-8-5.7-6
Payment or denial of claims; interest
Sec. 6. (a) An insurer shall pay or deny each clean claim as follows:
(1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer.
(2) If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer.
(b) If:
(1) an insurer fails to pay or deny a clean claim in the time required under subsection (a); and
(2) the insurer subsequently pays the claim;
the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.
(c) Interest paid under subsection (b):
(1) accrues beginning:
   (A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or
   (B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and
(2) stops accruing on the date the claim is paid.
(d) In paying interest under subsection (b), an insurer shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

IC 27-8-5.7-7
Permitted forms
Sec. 7. A provider shall submit only the following forms for payment by an insurer:
(1) HCFA-1500.
(2) HCFA-1450 (UB-92).
(3) American Dental Association (ADA) claim form.

IC 27-8-5.7-8
Civil penalties
Sec. 8. (a) If the commissioner finds that an insurer has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess an aggregate civil penalty against the insurer according to the following schedule:
(1) If the insurer has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).
(2) If the insurer has paid at least sixty percent (60%) but less
than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the insurer has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the insurer's failure to achieve the standards established by this chapter is due to circumstances beyond the insurer's control.

(c) An insurer may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the insurer receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the insurer under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.


IC 27-8-5.7-9
Repealed
(Repealed by P.L.1-2007, SEC.248.)

IC 27-8-5.7-10
Claim payment errors

Sec. 10. (a) An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:

(1) request that the provider repay the overpayment; or

(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(b) An insurer may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the insurer.

(c) This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the claim on which the overpayment or underpayment was made.

As added by P.L.55-2006, SEC.1.

IC 27-8-5.7-11
Claim overpayment adjustment

Sec. 11. Every subsequent claim that is adjusted by an insurer for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason
for the adjustment, including:

(1) an identification of:
   (A) the claim on which the overpayment was made; and
   (B) if ascertainable, the party financially responsible for the
        overpaid amount; and

(2) the amount of the overpayment that is being reimbursed to
    the insurer through the adjusted subsequent claim.

As added by P.L.55-2006, SEC.2.
IC 27-8-5.8
Chapter 5.8. Insurance Benefit Cards

IC 27-8-5.8-1
"Accident and sickness insurance policy" defined
Sec. 1. As used in this chapter, "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, 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 limited benefit health insurance policy.
6. A short term insurance plan that:
   A. may not be renewed; and
   B. has a duration of not more than six (6) months.
7. A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
8. Worker's compensation or similar insurance.
9. A student health insurance policy.


IC 27-8-5.8-2
"Commissioner" defined
Sec. 2. As used in this chapter, "commissioner" means the insurance commissioner appointed under IC 27-1-1-2.


IC 27-8-5.8-3
"Insured" defined
Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under an accident and sickness insurance policy.


IC 27-8-5.8-4
Prescription drug information card
Sec. 4. (a) This section applies to an insurer that:
1. issues an accident and sickness insurance policy that provides coverage for prescription drugs or devices; and
2. issues a card or other technology for claims processing.
This section also applies to a third party administrator for self-insured plans, a pharmacy benefit manager, or a health benefit plan administered by the state if the administrator, manager, or plan issues a card or other technology described in subdivision (2).

(b) The card or other technology issued by an insurer or another
entity referred to in subsection (a) must contain uniform prescription drug information that complies with the requirements established under subsection (c).

(c) Prescription drug information cards or other technology must meet either of the following criteria:

1. Be in a format and contain information fields approved by the National Council for Prescription Drug Programs (NCPDP) as contained in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect on the October 1 most immediately preceding the issuance of the card.

2. Contain the following information:
   - The health benefit plan's name.
   - The insured's name, group number, and identification number.
   - A telephone number to inquire about pharmacy related issues.
   - The issuer's international identification number or ANSI BIN number, labeled as RxBIN.
   - The processor control number, labeled as RxPCN.
   - The insured's pharmacy benefits group number if different than the medical group number, labeled as RxGRP.

Only those fields listed in clauses (A) through (F) that are required for proper adjudication of the claim must appear on the card. If the card is used to adjudicate non-pharmacy claims, then the designation "Rx" listed in clauses (D) through (F) is not required to be used by the issuer.

(d) An insurer or an insurer's agents, contractors, or administrators, including pharmacy benefits managers, may not be required to issue a prescription drug information card or other technology to a person more than one (1) time during a twelve (12) month period.

(e) The prescription drug information cards or other technology issued under this section may be used for health insurance coverage other than the coverage to which this chapter applies.

IC 27-8-6  
Chapter 6. Reimbursement for Certain Medical Services

IC 27-8-6-0.1  
Application of certain amendments to chapter  
Sec. 0.1. The addition of section 4 of this chapter by P.L.153-1990 applies to a group or an individual policy or agreement providing comprehensive accident and health benefits that is issued, entered into, or renewed after June 30, 1990.  
As added by P.L.220-2011, SEC.437.

IC 27-8-6-1  
Professional services for which reimbursement authorized  
Sec. 1. Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever such policy, contract, plan, or agreement provides for reimbursement for any service which is in the lawful scope of practice of a duly licensed dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor, the person entitled to benefits or the person performing services under the policy, contract, plan, or agreement shall be entitled to reimbursement on an equal basis for such service, whether the service is performed by a physician, dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor duly licensed under the laws of this state.  

IC 27-8-6-2  
Prior policies  
Sec. 2. The provisions of section 1 of this chapter shall not apply to any policy, contract, plan, or agreement in effect prior to May 1, 1969.  
(Formerly: Acts 1969, c.409, s.2.) As amended by P.L.252-1985, SEC.311.

IC 27-8-6-3  
Application of amendments by Acts 1974, P.L.126  
Sec. 3. The amendments to this chapter made by Acts 1974, P.L.126 do not apply to a policy, contract, plan, or agreement in effect before June 11, 1974.  
As added by P.L.1-1989, SEC.55.

IC 27-8-6-4  
Reimbursement for services; application of section; prohibitions excluded  
Sec. 4. (a) This section does not apply to any of the following:  
(1) A health maintenance organization (as defined in IC 27-13-1-19) or limited service health maintenance
organization (as defined in IC 27-13-34-4).
(2) A preferred provider plan (as defined in IC 27-8-11-1).
(3) An employee benefit program that is subject to the federal Employee Retirement Income Security Act (29 U.S.C. 1001 et seq.).
(4) Worker's compensation for an injury to or occupational disease of an employee under IC 22-3.

(b) A group or individual policy or agreement providing comprehensive accident and health benefits must reimburse an insured for services rendered by a provider licensed under IC 25-10 within the scope of that provider's license in the same manner as that policy or agreement reimburses an insured for services rendered by a provider licensed under IC 25-22.5 within the scope of that provider's license. The policy or agreement may not exclude or otherwise limit reimbursement for any service that a provider licensed under IC 25-10 renders under the scope of that provider's license in the diagnosis and treatment of any illness or injury. This section does not require that a health care policy or agreement cover a particular illness or injury.

(c) This section does not prohibit the following:
   (1) The application of coinsurance and deductible provisions to providers licensed under IC 25-10 on the same basis as those provisions are applied to providers licensed under IC 25-22.5.
   (2) The application of cost containment or quality assurance measures to providers licensed under IC 25-10 on the same basis as those measures are applied to providers licensed under IC 25-22.5.
   (3) A review of the necessity of services that applies to services rendered by providers licensed under IC 25-10 on the same basis as the review applies to services provided by providers licensed under IC 25-22.5.


IC 27-8-6-5
Indemnity for services provided by certified registered nurse anesthetist

Sec. 5. (a) As used in this section, "certified registered nurse anesthetist" has the meaning set forth in IC 25-23-1-1.4.

(b) As used in this section, "insured" means an individual who is entitled to the benefits provided by a policy of accident and sickness insurance. The term includes the following:
   (1) The policyholder of an individual policy of accident and sickness insurance.
   (2) A member of the group covered by a group policy of accident and sickness insurance.
   (3) An individual who is entitled to coverage under a policy of accident and sickness insurance as a spouse or dependent of an individual referred to in subdivision (1) or (2).
(c) As used in this section, "insurer" has the meaning set forth in
(d) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

(e) An insurer that issued a policy of accident and sickness insurance that indemnifies an insured for anesthesiology services shall indemnify an insured under the policy for any covered anesthesiology services provided by a certified registered nurse anesthetist.  


IC 27-8-6-6  
Coverage for athletic trainer services

Sec. 6. (a) As used in this section, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. However, 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) A supplemental plan that always pays in addition to other coverage.

(b) A policy of accident and sickness insurance that provides coverage for physical medicine and rehabilitative services shall provide the coverage for physical medicine and rehabilitative services that are:

(1) rendered by an athletic trainer who is licensed under IC 25-5.1; and
(2) within the athletic trainer's scope of practice.

(c) This section does not require a policy of accident and sickness insurance to provide coverage for physical medicine or rehabilitative services generally.  

As added by P.L.133-2011, SEC.1.
IC 27-8-7
Repealed
(Repealed by P.L.26-1994, SEC.28.)
IC 27-8-8
Chapter 8. Indiana Life and Health Insurance Guaranty Association Law

IC 27-8-8-0.3 Coverage obligations affected by statutory amendments; governing law

Sec. 0.3. (a) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are not affected by changes made by P.L.193-2006.

(b) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are governed by this chapter as it existed on January 1, 2006.

(c) The amendments made during the 2013 regular session of the general assembly to section 2.1 of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(d) The amendment made during the 2013 regular session of the general assembly to section 2.3(e) of this chapter does not apply to a member insurer that has a coverage date before January 1, 2012.

(e) The amendments made during the 2013 regular session of the general assembly to section 2.3(f) of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.


IC 27-8-8-1 Repealed
(Repealed by P.L.193-2006, SEC.32.)

IC 27-8-8-1.5 Repealed
(Repealed by P.L.193-2006, SEC.32.)

IC 27-8-8-2 Definitions
Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Account" means one (1) of the two (2) accounts created under section 3 of this chapter.

(c) "Annuity contract", except as provided in section 2.3(e) of this chapter, includes:

(1) a guaranteed investment contract;
(2) a deposit administration contract;
(3) a structured settlement annuity;
(4) an annuity issued to or in connection with a government lottery; and
(5) an immediate or a deferred annuity contract.

(d) "Assessment base year" means, for an impaired insurer or insolvent insurer, the most recent calendar year for which required premium information is available preceding the calendar year during which the impaired insurer's or insolvent insurer's coverage date occurs.

(e) "Association", except when the context otherwise requires, means the Indiana life and health insurance guaranty association created by section 3 of this chapter.

(f) "Benefit plan" means a specific plan, fund, or program that is established or maintained by an employer or an employee organization, or both, that:

(1) provides retirement income to employees; or
(2) results in a deferral of income by employees for a period extending to or beyond the termination of employment.

(g) "Board" refers to the board of directors of the association selected under IC 27-8-8-4.

(h) "Called", when used in the context of assessments, means that notice has been issued by the association to member insurers requiring the member insurers to pay, within a time frame set forth in the notice, an assessment that has been authorized by the board.

(i) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(j) "Contractual obligation" means an enforceable obligation under a covered policy for which and to the extent that coverage is provided under section 2.3 of this chapter.

(k) "Coverage date" means, with respect to a member insurer, the date on which the earlier of the following occurs:

(1) The member insurer becomes an insolvent insurer.
(2) The association determines that the association will provide coverage under section 5(a) of this chapter with respect to the member insurer.

(l) "Covered policy" means a:

(1) nongroup policy or contract;
(2) certificate under a group policy or contract; or
(3) part of a policy, contract, or certificate described in subdivisions (1) and (2);

for which coverage is provided under section 2.3 of this chapter.

(m) "Extracontractual claims" includes claims that relate to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

(n) "Funding agreement" has the meaning set forth in IC 27-1-12.7-1.

(o) "Impaired insurer" means a member insurer that is:

(1) not an insolvent insurer; and
(2) placed under an order of rehabilitation or conservation by a court with jurisdiction.

(p) "Insolvent insurer" means a member insurer that is placed under an order of liquidation with a finding of insolvency by a court with jurisdiction.
(q) "Member insurer" means any person that holds a certificate of authority to transact in Indiana any kind of insurance for which coverage is provided under section 2.3 of this chapter. The term includes an insurer whose certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include the following:

1. A for-profit or nonprofit hospital or medical service organization.
3. A fraternal benefit society under IC 27-11.
4. The Indiana Comprehensive Health Insurance Association or any other mandatory state pooling plan or arrangement.
5. An assessment company or another person that operates on an assessment plan (as defined in IC 27-1-2-3(y)).
6. An interinsurance or reciprocal exchange authorized by IC 27-6-6.
7. A prepaid limited service health maintenance organization or a limited service health maintenance organization under IC 27-13-34.
8. A farm mutual insurance company under IC 27-5.1.
9. A person operating as a Lloyds under IC 27-7-1.
10. The political subdivision risk management fund established by IC 27-1-29-10 and the political subdivision catastrophic liability fund established by IC 27-1-29.1-7.
11. The small employer health reinsurance board established by IC 27-8-15.5-5.
12. A person similar to any person described in subdivisions (1) through (11).

(r) "Moody's Corporate Bond Yield Average" means:

1. the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc.; or
2. if the monthly average described in subdivision (1) is no longer published, an alternative publication of interest rates or yields determined appropriate by the association.

(s) "Multiple employer welfare arrangement" has the meaning set forth in IC 27-1-34-1.

(t) "Owner" means the person:

1. identified as the legal owner of a policy or contract according to the terms of the policy or contract; or
2. otherwise vested with legal title to a policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer.

The term does not include a person with a mere beneficial interest in a policy or contract.

(u) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a governmental entity, a voluntary organization, a trust, a trustee, or another business entity or
(v) "Plan sponsor" refers to only one (1) of the following with respect to a benefit plan:

1. The employer, in the case of a benefit plan established or maintained by a single employer.
2. The holding company or controlling affiliate, in the case of a benefit plan established or maintained by affiliated companies comprising a consolidated corporation.
3. The employee organization, in the case of a benefit plan established or maintained by an employee organization.
4. In a case of a benefit plan established or maintained:
   A. by two (2) or more employers;
   B. by two (2) or more employee organizations; or
   C. jointly by one (1) or more employers and one (1) or more employee organizations;
and that is not of a type described in subdivision (2), the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan.

(w) "Premiums" means amounts, deposits, and considerations received on covered policies, less returned premiums, returned deposits, returned considerations, dividends, and experience credits. The term does not include the following:

1. Amounts, deposits, and considerations received for policies or contracts or parts of policies or contracts for which coverage is not provided under section 2.3(d) of this chapter, as qualified by section 2.3(e) of this chapter, except that an assessable premium must not be reduced on account of the limitations set forth in section 2.3(e)(3), 2.3(e)(15), or 2.3(f)(2) of this chapter.
2. Premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued or not connected with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(x) "Principal place of business" refers to the single state in which individuals who establish policy for the direction, control, and coordination of the operations of an entity as a whole primarily exercise the direction, control, and coordination, as determined by the association in the association's reasonable judgment by considering the following factors:

1. The state in which the primary executive and administrative headquarters of the entity is located.
2. The state in which the principal office of the chief executive officer of the entity is located.
3. The state in which the board of directors or similar governing person of the entity conducts the majority of the board of directors' or governing person's meetings.
4. The state in which the executive or management committee of the board of directors or similar governing person of the entity conducts the majority of the committee's meetings.
5. The state from which the management of the overall
operations of the entity is directed. However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are employed in a single state, that state is considered to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subsection (v)(4), if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are not employed in a single state, is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan and, in the absence of a specific or clear designation of a principal place of business, is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question on the coverage date.

(y) "Receivership court" refers to the court in an insolvent insurer's or impaired insurer's state that has jurisdiction over the conservation, rehabilitation, or liquidation of the insolvent insurer or impaired insurer.

(z) "Resident" means the following:

(1) An individual who resides in Indiana on the applicable coverage date.

(2) A person that is not an individual and has the person's principal place of business in Indiana on the applicable coverage date.

(aa) "State" includes a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(bb) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(cc) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(dd) "Unallocated annuity contract" means an annuity contract or group annuity certificate:

(1) the owner of which is not a natural person; and
(2) that does not identify at least one (1) specific natural person as an annuitant;

except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For purposes of this chapter, an unallocated annuity contract shall not be considered a group policy or group contract.


IC 27-8-8-2.1
Policy and contract descriptions; plan sponsor; residency
Sec. 2.1. (a) For purposes of this chapter:
(1) a policy or contract issued on a blanket basis is a group policy or group contract;
(2) each individual insured under a policy or contract issued on a blanket basis is a certificate holder under the policy or contract; and
(3) a policy or contract issued on a franchise plan to members of a qualified group is a nongroup policy or nongroup contract.
(b) For purposes of this chapter, a benefit plan may have only one (1) plan sponsor.
(c) For purposes of this chapter, an individual who, on the applicable coverage date:
   (1) is a citizen of the United States; and
   (2) resides in a:
       (A) foreign country; or
       (B) United States possession, territory, or protectorate;
       that does not have an association similar to the association created by this chapter;
is considered to be a resident of the state of domicile of the insurer that issued the policies or contracts.

IC 27-8-8-2.3
Coverage provided; exclusions; limitations
Sec. 2.3. (a) Except as otherwise excluded or limited by this chapter, this chapter provides coverage for policies and contracts specified in subsection (d) as follows:
(1) To a person, other than a certificate holder under a group policy or a group contract, that, regardless of where the person resides, is the beneficiary, nonowner assignee, or payee of a person covered under subdivision (2).
(2) To a person that is a certificate holder under a group policy or group contract, and to a person that is the owner of a nongroup policy or nongroup contract that is not an unallocated annuity contract or a structured settlement annuity, and that:
   (A) is a resident; or
   (B) is not a resident if all the following conditions are satisfied:
       (i) The member insurer that issued the policy or contract is domiciled in Indiana.
       (ii) The state in which the person resides has an association similar to the association.
       (iii) The nonresident is not eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.
(3) For an unallocated annuity contract, subdivisions (1) and (2) do not apply, and this chapter provides coverage to the following:
(A) A person that is the owner of the unallocated annuity contract, if the contract was issued to or in connection with a benefit plan whose plan sponsor is a resident or, if the plan sponsor is not a resident, if all the following conditions are satisfied:
   (i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.
   (ii) The state in which the plan sponsor resides has an association similar to the association.
   (iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.
(B) A person that is the owner of an unallocated annuity contract issued to or in connection with a government lottery, if the owner is a resident or, if the owner is not a resident, if all the following conditions are satisfied:
   (i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.
   (ii) The state in which the owner resides has an association similar to the association.
   (iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.
(4) For a structured settlement annuity, subdivisions (1) and (2) do not apply, and this chapter provides coverage to a person that is a payee under the structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:
   (A) is a resident, regardless of where the contract owner resides; or
   (B) is not a resident if all the following conditions are satisfied:
      (i) The member insurer that issued the structured settlement annuity is domiciled in Indiana.
      (ii) The state in which the payee resides has an association similar to the association.
      (iii) Neither the payee nor the beneficiary of the payee (if the payee is deceased) is eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.
(b) This chapter does not provide coverage to a person that is:
   (1) a payee or beneficiary of a contract owner that is a resident, if the payee or beneficiary is afforded any coverage by the association of another state; or
   (2) otherwise covered under subsection(a)(3), if any coverage is
provided to the person by the association of another state.

(c) To avoid duplicate coverage, if a person that would otherwise receive coverage under this chapter is provided coverage under the laws of another state, the person is not eligible for coverage under this chapter. In determining the application of this subsection when a person may be covered by the association of more than one (1) state as an owner, a payee, a beneficiary, or an assignee, this chapter must be construed in conjunction with the laws of the other state to result in coverage by only one (1) association.

(d) Except as otherwise excluded or limited by this chapter, this chapter provides coverage to the persons specified in subsection (a) for:

1. direct nongroup life, health, or annuity policies and contracts and supplemental contracts to direct nongroup life, health, or annuity policies and contracts;
2. certificates under direct group life, health, and annuity policies and contracts; and
3. unallocated annuity contracts;

issued by member insurers.

(e) This chapter does not provide coverage for or with respect to the following:

1. A part of a certificate, policy, or contract:
   (A) not guaranteed by the insurer; or
   (B) under which the risk is borne by the payee, certificate holder, or the policy or contract owner.
2. A reinsurance policy or contract, unless and to the extent that assumption certificates have been issued under the reinsurance policy or contract.
3. A part of a certificate, policy, or contract to the extent that the certificate's, policy's, or contract's interest rate, crediting rate, or similar factor employed in calculating returns or changes in values, whether expressly stated in the certificate, policy, or contract or determined by use of an index or other external referent stated in the certificate, policy, or contract, either:
   (A) when averaged over a period of four (4) years immediately before the applicable coverage date, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for the same four (4) year period or for a lesser period if the certificate, policy, or contract was issued less than four (4) years before the applicable coverage date; or
   (B) in effect under the certificate, policy, or contract on and after the applicable coverage date, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available on the applicable coverage date.
4. The obligations of a plan or program of an employer, an association, or another person to provide life, health, or annuity benefits to the employer's, association's, or other person's employees, members, or others, including obligations arising
under and benefits payable by the employer, association, or other person under a multiple employer welfare arrangement.

(5) A minimum premium group insurance plan.

(6) A stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan, or another person obligated to pay life, health, or annuity benefits or to provide services in connection with a benefit plan or another plan, fund, or program for the provision of employee welfare or pension benefits.

(7) An administrative services only contract.

(8) A part of a certificate, policy, or contract to the extent that the certificate, policy, or contract provides for:
   (A) dividends or experience rating credits;
   (B) voting rights; or
   (C) payment of fees or allowances to a person, including the certificate holder or policy or contract owner, in connection with service with respect to or administration of the certificate, policy, or contract.

(9) A certificate, policy, or contract issued in Indiana by a member insurer when the member insurer did not have a certificate of authority to issue the certificate, policy, or contract in Indiana.

(10) An unallocated annuity contract issued to or in connection with a benefit plan protected by the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet been required to make payments with respect to the benefit plan.

(11) An unallocated annuity contract or part of an unallocated annuity contract that is not issued to or in connection with a benefit plan or a government lottery.

(12) A certificate, policy, or contract or part of a certificate, policy, or contract with respect to which the Class B assessments contemplated by section 6 of this chapter may not be made or collected under federal or state law.

(13) An obligation or claim that does not arise under the express written terms of the policy or contract issued by the member insurer to the contract owner or policy owner, including any of the following obligations and claims:
   (A) Obligations and claims based on marketing materials.
   (B) Obligations and claims based on side letters, riders, or other documents issued by the member insurer without meeting applicable policy form filing or approval requirements.
   (C) Obligations and claims based on actual or alleged misrepresentations.
   (D) Obligations and claims that are extracontractual claims.
   (E) Obligations and claims for penalties or consequential, incidental, punitive, or exemplary damages.

(14) An obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference
to a portfolio of assets that is owned by the:
   (A) benefit plan; or
   (B) benefit plan's trustee;
that is not an affiliate of the member insurer.

(15) A part of a certificate, policy, or contract to the extent the:
   (A) certificate, policy, or contract provides for the
       certificate's, policy's, or contract's interest rate, crediting rate,
       or similar factor employed in calculating returns or changes
       in values, to be determined by use of an index or other
       external referent stated in the certificate, policy, or contract;
       and
   (B) returns or changes in value have not been credited to the
       certificate, policy, or contract, or as to which the certificate
       holder's or policy or contract owner's rights are subject to
       forfeiture, as of the applicable coverage date.
If a certificate's, policy's, or contract's returns or changes in
values are credited to the certificate, policy, or contract less
frequently than annually, for purposes of determining the
returns and values that have been credited and are not subject to
forfeiture under this subdivision, the returns and changes in
value determined by using the procedures defined in the
certificate, policy, or contract must be considered credited as if
the contractual date of crediting returns or changes in values
were the applicable coverage date, and those credited returns or
changes in value are not subject to forfeiture under this
subdivision, but will be subject to any other applicable
limitations under this chapter.

(16) A funding agreement.

(17) An annuity not subject to regulation as described in
IC 27-1-12.4.

(18) A certificate, policy, or contract that provides a hospital,
medical, prescription drug, or other health care benefit under:
   (A) Part C of Title XVIII of the federal Social Security Act
       (42 U.S.C. 1395w-21 through 1395w-28);
   (B) Part D of Title XVIII of the federal Social Security Act
       (42 U.S.C. 1395w-101 through 1395w-153); or
   (C) regulations adopted under a law specified in clause (A)
       or (B).

   (f) The benefits that the association is obligated to cover do not
   exceed the lesser of the following:
   (1) The contractual obligations for which the member insurer is
       liable or would have been liable if the member insurer were not
       an impaired insurer or insolvent insurer.
   (2) The applicable limitations as follows:
       (A) With respect to certificates, policies, and contracts not
           subject to clause (B), (C), (E), or (F), with respect to one (1)
           life, regardless of the number of policies or contracts, the
           following limitations:
           (i) Three hundred thousand dollars ($300,000) in life
               insurance death benefits, but not more than one hundred
thousand dollars ($100,000) in net cash surrender and net cash withdrawal values.

(ii) One hundred thousand dollars ($100,000) in health insurance benefits (other than disability insurance, basic hospital, medical, and surgical insurance, major medical insurance, and long term care insurance), including net cash surrender and net cash withdrawal values.

(iii) Three hundred thousand dollars ($300,000) in health insurance benefits that are disability insurance.

(iv) Three hundred thousand dollars ($300,000) in health insurance benefits under one (1) or more long term care insurance policies (as defined in IC 27-8-12-5).

(v) Five hundred thousand dollars ($500,000) in health insurance benefits that are basic hospital, medical, and surgical insurance or major medical insurance.

(vi) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) With respect to unallocated annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participant.

(C) With respect to structured settlement annuities, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per payee.

(D) In addition to the foregoing limitations, the association is not obligated to cover more than:

(i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) person under clauses (A), (B), and (C), except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under clause (A)(v), an aggregate of five hundred thousand dollars ($500,000) with respect to any one (1) person; or

(ii) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, a firm, a corporation, or another person, and whether the persons insured are officers, managers, employees, or other persons, five million dollars ($5,000,000) in benefits, including net cash surrender and net cash withdrawal values, regardless of the number of policies and contracts held by the owner.

(E) With respect to unallocated annuity contracts issued to or in connection with a government lottery, five million dollars ($5,000,000) in benefits per contract owner, regardless of the number of contracts held by the contract owner.
(F) With respect to unallocated annuity contracts:
   (i) issued to or in connection with a benefit plan; and
   (ii) not subject to clause (B);
   five million dollars ($5,000,000) in benefits per plan
sponsor, regardless of the number of unallocated annuity
contracts entitled to coverage under this chapter.

(g) The limitations set forth in subsection (f) are limitations on the
benefits for which the association is obligated before taking into
account the:
   (1) association's subrogation and assignment rights; or
   (2) extent to which the benefits could be provided out of the
assets of the impaired insurer or insolvent insurer attributable to
covered policies.

The costs of discharging the association's obligations under this
chapter may be met by the use of assets attributable to covered
policies or reimbursed to the association under the association's
subrogation and assignment rights.

(h) In discharging the association's obligations to provide coverage
under this chapter, the association is not required to:
   (1) guarantee, assume, reinsure, or perform;
   (2) cause to be guaranteed, assumed, reinsured, or performed; or
   (3) otherwise assure the discharge of;
   the obligations of the insolvent insurer or impaired insurer under a
covered policy that do not materially affect the economic values or
economic benefits of the covered policy.

As added by P.L.193-2006, SEC.11. Amended by P.L.276-2013,
SEC.33.

IC 27-8-8-3
Creation of association; membership; accounts; supervision

Sec. 3. (a) There is created a nonprofit legal entity referred to as
the Indiana Life and Health Insurance Guaranty Association. A
member insurer shall be and remain a member of the association as
a condition of the member insurer's authority to transact insurance in
Indiana. The association shall perform its functions under the plan of
operation established and approved under section 7 of this chapter.
The association shall exercise its powers through a board of directors
established under section 4 of this chapter. For purposes of
administration and assessment the association shall maintain the
following two (2) accounts:
   (1) The health insurance account.
   (2) The life insurance and annuity account, which includes the
following subaccounts:
      (A) The life insurance subaccount.
      (B) The annuity subaccount, which includes annuity
contracts issued to or in connection with a governmental
benefit plan established under Section 401, 403(b), or 457 of
the United States Internal Revenue Code, but otherwise
excludes unallocated annuities.
      (C) The unallocated annuity subaccount, which excludes
annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(b) The association is under the immediate supervision of the commissioner and subject to the applicable provisions of the insurance laws of Indiana.


IC 27-8-8-4
Board of directors

Sec. 4. (a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner.

(b) Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(c) To select the initial board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one (1) vote in person or by proxy. If the board is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members of the board.

(d) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(e) Members of the board may be reimbursed from the assets of the association for expenses incurred by the members as members of the board. The association shall not otherwise compensate members of the board for the members' services on the board.


IC 27-8-8-5
Impaired insurers; insolvent insurers; liens; association powers and duties

Sec. 5. (a) If a member insurer is an impaired insurer, the association may, in the association's sole discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of any of the covered policies of the impaired insurer or otherwise assure the discharge of the contractual obligations of the covered policies of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or use other means as determined by the association in the association's
sole discretion to be necessary or appropriate to effectuate subdivision (1).

(b) An obligation undertaken by the association under subsection (a) with respect to a covered policy of an impaired insurer ceases on the date the covered policy is replaced by the policy owner, insured, or association.

(c) If a member insurer is an insolvent insurer, the association shall, in the association's sole discretion, do one (1) of the following for each covered policy:

(1) Guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the covered policy or otherwise assure the discharge of the contractual obligations of the covered policy.

(2) Terminate existing benefits and coverage and provide benefits and coverages in accordance with the following provisions:

   (A) For premiums identical to the premiums that would have been payable under the covered policy, assure payment of benefits arising under the contractual obligations, except for terms of conversion and nonrenewability, for:

      (i) with respect to a group covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or forty-five (45) days, but not less than thirty (30) days, after the coverage date for the insolvent insurer; and

      (ii) with respect to a nongroup covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or one (1) year, but in no event less than thirty (30) days, after the coverage date for the insolvent insurer.

   (B) Make diligent efforts to provide each:

      (i) known insured or annuitant, for a nongroup covered policy; and

      (ii) owner, for a group covered policy;

   at least thirty (30) days notice of the termination of the benefits provided.

   (C) Make available substitute coverage, on an individual basis, to each:

      (i) owner of a nongroup covered policy if the owner had a right to continue the nongroup covered policy in force until a specified age or for a specified period, during which time the insurer had no unilateral right to make changes in the nongroup covered policy's provisions or had only a unilateral right to make changes in premiums only by class; and

      (ii) insured or annuitant under a group covered policy if the insured or annuitant is not eligible for any replacement group coverage and had a right, before termination of the group covered policy, to convert to individual coverage.

   (D) In making available any substitute coverage under clause
(C), the association may offer to reissue the terminated coverage or to issue an alternative policy or contract. If made available under clause (C), alternative or reissued policies and contracts must be offered without requiring evidence of insurability and must not impose any waiting period or coverage exclusion, other than a waiting period or coverage exclusion provided for in this chapter, that would not have applied under the terminated covered policy. The association may cause any alternative or reissued policy or contract to be assumed or reinsured.

(E) Use of alternative policies and contracts by the association is subject to the approval of the domiciliary insurance regulatory authority and the receivership court. The association may adopt alternative policies and contracts of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies and contracts must contain at least the minimum statutory provisions required in Indiana and provide benefits that are reasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must:

(i) reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) not reflect changes in the health of the insured after the terminated covered policy was last underwritten.

Subject to coverage exceptions, exclusions, and limitations provided for in this chapter, an alternative policy or contract issued by the association must provide coverage similar, in material respects, to the coverage under the terminated covered policy as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from the premium rate charged under the terminated covered policy, the association shall set the premium in accordance with a table of rates adopted by the association. The premium:

(i) must reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) is subject to approval of the domiciliary insurance regulatory authority and the receivership court.

(G) The association's obligations with respect to coverage under a covered policy of an insolvent insurer or under a reissued or alternative policy or contract ceases on the date the coverage or covered policy is replaced by another similar policy by the policy owner, insured, or association.

(H) Subject to subsection (u), when proceeding under this subdivision with respect to a covered policy carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 2.3(e)(3) of this chapter.

(3) Take any combination of the actions set forth in subdivisions
The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state of the impaired insurer or insolvent insurer if the domiciliary state is a state other than Indiana.

(h) In carrying out its duties under subsection (c), the association may, subject to approval by a court in Indiana, impose:

1) permanent policy or contract liens, if the association finds that:

   (A) the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter; or
   (B) economic or financial conditions, as they affect member insurers, are sufficiently adverse so as to render the imposition of the permanent policy or contract liens to be in the public interest; and

2) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with a covered policy, in addition to any contractual provisions for deferral of cash or policy loan value.

In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payments of cash values or policy loans or any other right to withdraw funds held in conjunction with a covered policy out of the assets of the impaired insurer or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(i) A deposit in Indiana, held by law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver before or promptly after the coverage date for an impaired insurer or insolvent insurer under IC 27-9-4-3 must be promptly paid to the association. The
association:
(1) may retain a part of an amount paid to the association under this subsection equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to the impairment or insolvency for which the association provides statutory benefits by the aggregate amount of all policy owners' claims in Indiana related to the impairment or insolvency; and
(2) shall remit to the domiciliary receiver the difference between the amount paid to the association and the amount retained by the association under this subsection.

An amount retained by the association under this subsection must be treated as a distribution of estate assets under IC 27-9-3-32 or similar provision of the state of domicile of the impaired insurer or insolvent insurer.

(j) If the association fails to act within a reasonable period of time as provided in subsection (c) with respect to an insolvent insurer, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(k) The association may, upon the commissioner's request, assist and advise the commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

(l) The association has standing and the right to appear or intervene before a court or an agency in Indiana or elsewhere with jurisdiction over an impaired insurer or insolvent insurer for which the association is or may become obligated under this chapter or with jurisdiction over a person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the rights, powers, and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired insurer or insolvent insurer and the determination of the policies or contracts and contractual obligations.

(m) A person receiving benefits under this chapter is considered to have assigned:
(1) the person's rights under; and
(2) any cause of action against another person for losses arising under, resulting from, or otherwise relating to;
the covered policy to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations or continuation of coverage or provision of substitute or alternative coverage. The association may require an assignment to it of those rights and causes of action by a payee, policy or contract owner, certificate holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter on the person.

(n) The subrogation rights of the association under subsections (m) and (o) have the same priority against the assets of the impaired insurer or insolvent insurer as those possessed by the person entitled
to receive benefits under this chapter.

(o) In addition to the rights conferred by subsections (m) and (n), the association has all common law rights of subrogation and any other equitable or legal remedy with respect to a covered policy that would have been available to the:

1. impaired insurer or insolvent insurer;
2. owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including, in the case of a structured settlement annuity, rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person:
   A. who is originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity; and
   B. whose responsibility is not solely because of the person serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code; and
3. certificate holder, or the beneficiary or payee of the certificate holder, with respect to a certificate.

(p) If subsection (m), (n), or (o) is invalid or ineffective with respect to a person or claim, the amount payable by the association with respect to the related covered policies must be reduced by the amount realized by another person with respect to the person or claim that is attributable to the covered policies.

(q) If the association provides benefits with respect to a covered policy and a person recovers amounts to which the association has rights as described in subsection (m), (n), or (o), the person shall pay to the association the part of the recovery attributable to the covered policies.

(r) The association may do the following:

1. Enter into contracts necessary or appropriate to carry out the provisions and purposes of this chapter.
2. Sue or, subject to section 14 of this chapter, be sued, including taking legal actions necessary or appropriate to recover unpaid assessments under section 6 of this chapter and to resolve claims or potential claims against or on behalf of the association.
3. Borrow money to effect the purposes of this chapter and issue notes or other evidences of indebtedness of the association with respect to borrowings. Notes or other evidences of indebtedness described in this subdivision that are not in default are legal investments for domestic insurers and may be carried as admitted assets.
4. Employ or retain persons necessary or appropriate to handle the financial transactions of the association and to perform other functions necessary or appropriate under this chapter.
5. Take legal action necessary or appropriate to avoid or recover payment of improper claims.
6. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or
health insurer. However, in no case may the association issue insurance policies or annuity contracts other than those issued to perform the association's obligations under this chapter.

(7) Request information from a person seeking coverage from the association to aid the association in determining and discharging the association's obligations under this chapter with respect to the person. The person shall promptly comply with the request.

(8) Settle claims and potential claims by or against the association.

(9) Exercise all rights, privileges, and powers granted to the association by any other laws of Indiana or another jurisdiction.

(10) Take other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's rights and powers under this chapter.

(s) The association may belong to one (1) or more organizations of one (1) or more other state associations of similar purpose to further the purpose and administer the powers and duties of the association.

(t) The association has discretion and may exercise reasonable business judgment to determine the means by which the association is to discharge, in an economical and efficient manner, the association's obligations under this chapter.

(u) In discharging the association's obligations and exercising the association's rights and powers under subsections (a) and (c), the association may, subject to approval of the receivership court, provide substitute coverage for a covered policy that provides for the covered policy's interest rate, crediting rate, or similar factor employed in calculating returns or changes in value to be determined by use of an index or other external referent stated in the covered policy by issuing an alternative policy or contract in accordance with the following provisions:

(1) Instead of the index or other external referent stated in the covered policy, the alternative policy or contract may provide for:
   (A) a fixed interest rate;
   (B) payment of dividends with minimum guarantees; or
   (C) a different method for calculating returns or changes in value.

(2) A:
   (A) requirement for evidence of insurability; or
   (B) waiting period or an exclusion, other than a waiting period or an exclusion provided for in this chapter; that would not have applied under the covered policy may not be imposed.

(3) The alternative policy or contract must provide coverage similar, in material respects, to the coverage under the covered policy, after taking into account the exceptions, exclusions, and limitations provided for in this chapter, as determined by the association.
IC 27-8-8-5.2
Association election to succeed to rights and duties of impaired or insolvent insurer; reinsurance

Sec. 5.2. (a) At any time within one (1) year after the coverage date for an impaired insurer or insolvent insurer, the association may elect, subject to subdivisions (1) through (4), to succeed to the rights and obligations of the impaired insurer or insolvent insurer that accrue on or after the coverage date and that relate to covered policies under one (1) or more indemnity reinsurance agreements entered into by the impaired insurer or insolvent insurer as a ceding insurer. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the impaired insurer or insolvent insurer has previously and expressly disaffirmed the reinsurance agreement. The election by the association must be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers specifying the reinsurance agreement concerning which the association has made the foregoing election. If the association makes an election, the following apply with respect to the agreements selected by the association:

(1) The association is responsible for:
   (A) all unpaid premiums due under the agreements for periods before and after the coverage date; and
   (B) the performance of all other obligations of the impaired insurer or insolvent insurer to be performed after the coverage date;
that relate to covered policies. The association may charge covered policies that are only partially covered by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.
(2) The association is entitled to any amount payable by the reinsurer under the selected agreements:
   (A) with respect to losses or events that occur during periods after the coverage date; and
   (B) that relate to covered policies.
Of the amount received from the reinsurer, the association is obliged to pay to the beneficiary under the covered policy on account of which the amount was paid a portion of the amount equal to the excess of the amount received by the association over benefits paid by the association on account of the covered policy less the retention of the impaired insurer or insolvent insurer applicable to the loss or event.
(3) Within thirty (30) days after the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by the:
(A) impaired insurer or insolvent insurer, or the impaired insurer's or insolvent insurer's receiver, rehabilitator, or liquidator; or
(B) indemnity reinsurer;
during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other not more than five (5) days after the completion of the calculation. If the receiver, rehabilitator, or liquidator has received any amount due the association under subdivision (2), the receiver, rehabilitator, or liquidator shall remit the amount to the association as promptly as practicable.

(4) If the association, within sixty (60) days of the election, pays the premiums due for periods before and after the coverage date that relate to covered policies, the reinsurer is not entitled to:
(A) terminate the reinsurance agreements insofar as the agreements relate to covered policies; or
(B) set off any unpaid premium due for periods before the coverage date against amounts due the association.

(b) If the association transfers any of the association's obligations to another insurer, and if the association and the other insurer agree, the other insurer succeeds to the rights and obligations of the association under subsection (a) with respect to the transferred obligations effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in subsection (a), except that the:
(1) indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary; and
(2) obligations of the association described in subsection (a)(2) no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer.
This subsection does not apply if the association has previously notified the receiver, rehabilitator, or liquidator and the affected reinsurer in writing that the association will not exercise the election referred to in subsection (a).

(c) Subsections (a) and (b) supersede any other law or affected reinsurance agreement that provides for or requires payment of reinsurance proceeds, on account of losses or events that occur after the coverage date, to the receiver, liquidator, or rehabilitator of the impaired insurer or insolvent insurer. The receiver, rehabilitator, or liquidator remains entitled to amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur before the coverage date, subject to applicable setoff provisions.

(d) Except as provided in subsections (a), (b), and (c), this chapter does not alter or modify the terms and conditions of indemnity reinsurance agreements of the insolvent insurer.
(e) This chapter does not:
(1) abrogate or limit the rights of a reinsurer to claim that the reinsurer is entitled to rescind a reinsurance agreement; or
(2) give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

As added by P.L.193-2006, SEC.15.

IC 27-8-8-5.4
Association obligations to person entitled to coverage
Sec. 5.4. If the association has arranged or offered to discharge the association's obligations under this chapter with respect to contractual obligations owed to a person entitled to coverage under this chapter:
(1) the person, and any other person claiming by, through, or under the person, is not entitled to benefits from the association in addition to or other than benefits arranged or offered by the association; and
(2) the association is relieved of further obligation with respect to the contractual obligations if the person rejects, declines, or otherwise fails to accept the association's arrangement or offer.

As added by P.L.193-2006, SEC.16.

IC 27-8-8-5.5
Venue; appeal bond
Sec. 5.5. (a) Venue in a suit against the association is in Marion County.
(b) The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under or with respect to this chapter.

As added by P.L.193-2006, SEC.17.

IC 27-8-8-6
Assessments
Sec. 6. (a) For the purpose of providing funds necessary to carry out the powers and duties of the association and necessary to pay administrative costs and expenses incurred by the commissioner in supervising the association and discharging the commissioner's obligations under this chapter, the board shall assess the member insurers, separately for each account, at a time and for amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and accrue interest at six percent (6%) per annum on and after the due date.
(b) There are two (2) classes of assessments as follows:
(1) Class A assessments are assessments that are authorized and called by the board for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired insurer or insolvent insurer.
(2) Class B assessments are assessments that are authorized and called by the board to the extent necessary to carry out the powers and duties of the association under this chapter with regard to an impaired insurer or insolvent insurer.
(c) The amount of a Class A assessment must be determined by
the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future Class B assessments. The total of all non-pro rata assessments must not exceed one hundred fifty dollars ($150) per member insurer in any one (1) calendar year.

(d) The amount of a Class B assessment must be allocated for assessment purposes among the accounts under an allocation formula that may be based on the premiums or reserves of the impaired insurer or insolvent insurer or another standard considered by the board in the board's sole discretion as fair and reasonable under the circumstances.

(e) Class B assessments against member insurers for each account and subaccount with respect to an impaired insurer or insolvent insurer must be allocated among the assessed member insurers in the proportion that the premiums received in Indiana by each assessed member insurer on policies and contracts covered by the account or subaccount during the assessment base year for the impaired insurer or insolvent insurer bears to premiums received in Indiana by all assessed members on policies and contracts covered by the same account or subaccount during the same assessment base year.

(f) Assessments for funds to meet the requirements of the association with respect to an impaired insurer or insolvent insurer must not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) and computation of assessments under subsections (c), (d), and (e) must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible. The association shall notify each member insurer of the member insurer's anticipated share of an assessment that has been authorized but not yet called not more than one hundred eighty (180) days after the assessment is authorized.

(g) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its policy and contract obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay assessments that were deferred under a repayment plan approved by the association.

(h) Subject to subsection (i), the total of all assessments authorized by the association in one (1) calendar year against a member insurer for a given subaccount of the life insurance and annuity account or for the health insurance account with respect to any single assessment base year must not exceed two percent (2%) of the member insurer's premiums received in Indiana on the policies and contracts covered by the subaccount or account during the applicable assessment base year.
(i) If two (2) or more assessments are authorized in one (1) calendar year with respect to impaired insurers or insolvent insurers having different assessment base years, the annual premium used for purposes of determining the aggregate assessment percentage limitation referenced in subsection (h) must be equal to the higher of the annual premiums for the applicable subaccount or account as calculated under this section.

(j) If the maximum assessment, together with other assets of the association in an account, does not provide in one (1) year in the account an amount sufficient to carry out the responsibilities of the association, additional funds must be assessed as soon as permitted by this chapter.

(k) The board may provide in the plan of operation a method of or procedure for allocating funds among claims relating to one (1) or more impaired insurers or insolvent insurers when the maximum assessment is insufficient to cover anticipated claims.

(l) If the maximum assessment for a subaccount of the life insurance and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, the board shall, under subsection (e), access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subsections (h) and (i).

(m) The board may, by an equitable method or procedure as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to the account, the amount by which the assets of the account exceed the amount the board determines is necessary to carry out the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for the future discharge of the association's obligations.

(n) It is proper for a member insurer, in determining its premium rates and policyowner dividends as to any type of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(o) The association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount and period of time as the commissioner may approve.


IC 27-8-8-6.2

Member protesting assessment
Sec. 6.2. (a) A member insurer that wishes to protest all or part of an assessment made under section 6 of this chapter shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or a subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and set forth a brief statement of the grounds for the protest.

(b) Not more than sixty (60) days after the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of the association's determination with respect to the protest (unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest).

(c) Not more than sixty (60) days after receipt of notice of the association's determination with respect to a protest, the protesting member insurer may appeal the determination to the commissioner.

(d) Instead of making a determination with respect to a protest based on a question regarding the assessment base, the association may refer the protest to the commissioner for a determination, with or without a recommendation from the association.

(e) If a protest of an assessment is upheld, the amount paid by the protesting member insurer in error or excess must be returned to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.  


IC 27-8-8-6.5
Association requests for information

Sec. 6.5. (a) The association may request information from a member insurer to aid in the exercise of the association's power under sections 6 and 6.2 of this chapter.

(b) A member insurer that receives a request under subsection (a) shall promptly comply with the request.  


IC 27-8-8-7
Association plan of operation

Sec. 7. (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation that are necessary or appropriate to assure the fair, reasonable, and equitable administration of the association. The plan of operation and an amendment to the plan of operation are effective:

(1) if the plan or amendment is not disapproved by the commissioner within thirty (30) days after being submitted to the commissioner; or

(2) upon the commissioner's written approval, if sooner than the time set in subdivision (1).

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days from September 1, 1978, or if
at any other time the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary to effectuate the provisions of this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) A member insurer shall comply with the plan of operation.
(d) The plan of operation must, in addition to requirements stated elsewhere in this chapter establish:
    (1) procedures for handling the assets of the association;
    (2) the amount and method of reimbursing members of the board under section 4 of this chapter;
    (3) regular places and times for meetings, including, if desired by the association, telephone conference calls, of the board;
    (4) procedures for records to be kept of all financial transactions of the association, its agents, and the board;
    (5) procedures whereby selections for the board will be made and submitted to the commissioner; and
    (6) any additional procedures for assessments under sections 6 and 6.2 of this chapter.

The plan of operation may contain additional provisions necessary or appropriate for the execution of the powers and duties of the association.

(e) The plan of operation may provide that any or all powers and duties of the association, except those under sections 5(r)(3), 6, 6.2, and 6.5 of this chapter, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two (2) or more states. The corporation, association, or organization must be reimbursed for payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board and the commissioner and may be made only to a corporation, association, or organization that extends protection that is not substantially less favorable and effective than that provided by this chapter.

(f) To the extent and in the manner specified in the plan of operation, the board may create one (1) or more committees, each of which may exercise the authority of the board to the extent specified in the plan of operation or by the board.


IC 27-8-8-8
Powers and duties of commissioner; appeals to commissioner; notice of effect of chapter
Sec. 8. (a) The commissioner shall do the following:
    (1) Upon request of the board, provide the association with a statement of the premiums in Indiana and other appropriate states for each member insurer.
(2) When an impairment is declared and the amount of the impairment is determined, serve a demand on the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders. The failure of the insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Indiana of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on a member insurer that fails to pay an assessment when due. A forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) A final action of the association or the board may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court with jurisdiction in accordance with the Indiana law that applies to the actions or orders of the commissioner.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer or insolvent insurer may notify all interested persons of the effect of this chapter.


IC 27-8-8-9
Detection and prevention of insurer insolvencies or impairments; actions of board of directors

Sec. 9. (a) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall do the following:

(1) Notify the insurance regulatory authorities of all the other states not more than thirty (30) days after the date an action taken by the commissioner occurs when the commissioner takes any of the following actions against a member insurer:

(A) Revokes the member insurer's certificate of authority.
(B) Suspends the member insurer's certificate of authority.
(C) Issues a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from Indiana, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(2) Report to the association when the commissioner takes any of the actions set forth in subdivision (1) or when the commissioner has received a report from any other insurance
regulatory authority indicating that an action has been taken in another state. The report to the association must contain all significant details of the action taken or of the report received from another insurance regulatory authority.

(3) Report to the association when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be impaired or insolvent.

(4) Furnish to the association the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The association may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this chapter. The report and the information contained in the report must be kept confidential by the association until made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the association concerning a matter affecting the commissioner's duties and responsibilities in regard to the financial condition of member insurers and companies seeking admission to transact insurance business in Indiana.

(c) The association may, upon majority vote by the board, make reports and recommendations to the commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of any company seeking to do an insurance business in Indiana. The reports and recommendations are not public documents.

(d) The association may, upon majority vote by the board, notify the commissioner of any information indicating that a member insurer may be impaired or insolvent.

(e) The association may, upon majority vote by the board, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.


IC 27-8-8-10
Records of board meetings; disclosure of records; association status as creditor; application of impaired or insolvent insurer's assets

Sec. 10. (a) Records must be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties under sections 5, 5.2, and 5.4 of this chapter. Records of the association with respect to an impaired insurer or insolvent insurer must not be disclosed except:

(1) after the termination of the liquidation, rehabilitation, or conservation proceeding involving the impaired insurer or insolvent insurer; or

(2) upon the order of a court with jurisdiction if the order is made before the time described in subdivision (1).
This subsection does not limit the duty of the association to submit a report of its activities under section 12 of this chapter.

(b) For the purpose of carrying out its obligations under this chapter, the association is a creditor of the impaired insurer or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts that the association has received, from a person other than the impaired insurer or insolvent insurer, as subrogee under section 5(m), 5(o), and 5(q) of this chapter. Assets of the impaired insurer or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer or insolvent insurer as required by this chapter. "Assets attributable to covered policies", as used in this subsection, is that proportion of the assets that the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer or insolvent insurer.

(c) As a creditor of an impaired insurer or insolvent insurer under subsection (b) and consistent with IC 27-9-3-32, the association and other similar associations are entitled to receive disbursements of assets out of the marshaled assets, as the assets become available to reimburse the association or another similar association, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days after a member insurer becomes an insolvent insurer, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvenency, the association is entitled to make application to the receivership court for approval of the association's own proposal to disburse the assets.

(d) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the impaired insurer or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired insurer or insolvent insurer. In making the determination, the court shall consider the welfare of the policy owners of the continuing or successor insurer.

(e) A distribution to stockholders of an impaired insurer or insolvent insurer must not be made until the total amount of valid claims of the association, with interest, for funds expended in carrying out the association's powers and duties under sections 5, 5.2, 5.4, and 5.5 of this chapter with respect to the impaired insurer or insolvent insurer, have been fully recovered by the association.


IC 27-8-8-11
Distributions to affiliates; recovery

Sec. 11. (a) Subject to subsections (b) through (d), if an order for
liquidation or rehabilitation of an insurer domiciled in Indiana has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the filing of the petition for liquidation or rehabilitation.

(b) A distribution described in subsection (a) is not recoverable if the insurer shows that when the distribution was paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill the insurer's policy and contract obligations.

(c) A person who was an affiliate that controlled the insurer at the time a distribution described in subsection (a) was paid is liable up to the amount of distributions the person received. A person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if the distributions had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the policy and contract obligations of the insolvent insurer.

(e) If a person liable under subsection (c) is insolvent, the affiliates that controlled the person at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.


IC 27-8-8-12
Examination and regulation of association; financial report

Sec. 12. (a) The association is subject to examination and regulation by the commissioner. The association shall annually submit to the commissioner, not later than one hundred twenty (120) days after the end of the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

(b) Upon the request of a member insurer, the association shall provide to the member insurer a copy of the reports described in subsection (a).


IC 27-8-8-13
Association tax and fee exemption

Sec. 13. The association is exempt from payment of all fees and all taxes levied by Indiana or any of its political subdivisions, except taxes levied on real property.
IC 27-8-8-14
Liability for performance under chapter
Sec. 14. (a) A member insurer and the member insurer's agents and employees, the association and the association's agents and employees, members of the board and representatives of the members of the board, and the commissioner and the commissioner's representatives are not liable for and no cause of action of any nature arises or may be brought against them for or in connection with an action or omission by any of them in the exercise and performance of their rights, powers, and duties under this chapter.

(b) Immunity under this section extends to:
   (1) the participation in an organization of one (1) or more other state associations of similar purpose; and
   (2) an organization described in subdivision (1) and an agent or employee of the organization.


IC 27-8-8-15
Insolvent insurer proceedings; stay; setting aside judgment
Sec. 15. All proceedings in which an insolvent insurer is a party in any court in Indiana shall be stayed for one hundred eighty (180) days from the date an order of liquidation is entered to permit proper legal action by the association on matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and is entitled to defend against the suit on the merits.


IC 27-8-8-16
Recoupment of assessments
Sec. 16. A member insurer may take as a credit against premium taxes, adjusted gross income taxes, or any combination of them imposed by the state upon the member insurer's revenue or income not more than twenty percent (20%) of the amount of each assessment described in section 6 of this chapter for each calendar year following the year in which the assessment was paid until the assessment has been offset by either credits against the taxes or refunds from the association. If the member insurer ceases doing business, all uncredited assessments may be credited against the member insurer's premium taxes, adjusted gross income taxes, or a combination of the premium taxes and adjusted gross income taxes of the member insurer for the year the member insurer ceases doing business.

IC 27-8-8-17
Refunds from association
Sec. 17. (a) Sums acquired by refund under section 6(m) of this chapter from the association by member insurers and offset against taxes as provided by section 16 of this chapter shall be paid by the member insurers to the state in the manner required by the tax authorities.
(b) The association shall notify the commissioner when refunds under section 6 of this chapter have been made.

IC 27-8-8-18
Advertising referring to association; association summary document
Sec. 18. (a) A person, including an insurer, insurance producer, employee, agent, or affiliate of an insurer, shall not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, an advertisement, an announcement, or a statement, written or oral, that uses the existence of the association for the purpose of the sale of, solicitation of, inducement to purchase any form of insurance covered by this chapter. This section does not apply to the association or any other entity that does not sell or solicit insurance.
(b) Not later than January 1, 2007, the association shall:
(1) prepare a summary document:
(A) describing the general purposes and current limitations of this chapter; and
(B) complying with subsection (c); and
(2) submit the summary document to the commissioner for approval.
Sixty (60) days after the date on which the commissioner approves the summary document, a member insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document must also be available upon request by a policy owner. The distribution, delivery, or contents or interpretation of the summary document does not guarantee that the policy or contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The summary document must be revised by the association as amendment to this chapter requires. Failure to receive the summary document does not give a policy owner, a contract owner, a certificate holder, or an insured greater rights than the rights specified in this chapter.
(c) The summary document prepared under subsection (b) must contain a clear and conspicuous disclaimer on the face of the summary document. The commissioner shall approve the form and content of the disclaimer. The disclaimer must, at a minimum, convey all the following:

1. State the name and address of the association and the department of insurance.
2. Prominently warn that:
   - (A) the association might not cover the policy or contract; and
   - (B) even if coverage were currently provided, coverage is:
     - (i) subject to substantial limitations and exclusions;
     - (ii) generally conditioned on continued residence in Indiana; and
     - (iii) subject to possible change as a result of future amendments to this chapter and court decisions.
3. State the types of policies for which the association currently provides coverage.
4. State that the member insurer and the member insurer's agents are prohibited by law from using the existence of the association for the purpose of selling, soliciting, or inducing purchase of any form of insurance.
5. State that the policy owner or contract owner should not rely on coverage under this chapter when selecting an insurer.
6. Explain:
   - (A) rights available following; and
   - (B) procedures for filing a complaint to allege; a violation of any provision of this chapter.
7. Provide other information as directed by the commissioner, including sources for information that:
   - (A) is not proprietary; and
   - (B) is subject to disclosure under IC 5-14-3; concerning the financial condition of an insurer.

(d) A member insurer shall retain evidence of compliance with subsection (b) until the policy or contract for which the notice is given is no longer in effect.

IC 27-8-9
Chapter 9. Primary Motor Vehicle Insurance Coverage

IC 27-8-9-0.3
Certain amendments intended as restatement of section 8 of this chapter; P.L.226-1993 does not affect rights, liabilities, penalties, violations, or proceedings before May 10, 1993; treatments of references to section 8 of this chapter
Sec. 0.3. (a) The amendments made to this chapter and the addition of IC 27-8-4-9.5 by P.L.226-1993 are intended to be a restatement of section 8 of this chapter (before its repeal).
(b) The substantive operation and effect of section 8 of this chapter (before its repeal) continues uninterrupted.
(c) P.L.226-1993 does not affect:
(1) rights or liabilities accrued;
(2) penalties incurred;
(3) violations committed; or
(4) proceedings begun;
before May 10, 1993. Those rights, liabilities, penalties, offenses, or proceedings continue and shall be imposed and enforced under section 8 of this chapter (before its repeal) as if P.L.226-1993 had not been enacted.
(d) A reference in a statute or rule to section 8 of this chapter shall be treated after May 10, 1993, as a reference to either of the following, whichever applies:
(1) Section 10 of this chapter, as added by P.L.226-1993.
(2) Section 11 of this chapter, as added by P.L.226-1993.
As added by P.L.220-2011, SEC.439.

IC 27-8-9-1
Repealed
(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-2
Repealed
(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-3
Repealed
(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-4
Repealed
(Repealed by P.L.261-1983, SEC.6.)

IC 27-8-9-5
Application of chapter
Sec. 5. This chapter applies only to policies affording motor vehicle insurance coverage that are issued or renewed after August 31, 1983.
IC 27-8-9-6
Definitions
Sec. 6. (a) The definitions set forth in this section apply throughout this chapter.
(b) "Garage liability policy" refers to any motor vehicle liability insurance policy that affords coverage to a named insured engaged in the business of selling, leasing, repairing, servicing, delivering, testing, road testing, parking, or storing motor vehicles, but does not refer to a motor vehicle liability insurance policy that affords coverage to a vehicle used in the business of transporting property for hire.
(c) "Motor vehicle insurance coverage" means any type of insurance coverage described in IC 27-1-5-1, Class 2(f).
(d) "Permittee" means any person who is granted permission to operate a motor vehicle by the owner of the motor vehicle.

IC 27-8-9-7
Coverage for a permittee or passenger
Sec. 7. (a) This section does not apply to cases covered by section 10 or 11 of this chapter.
(b) In any case arising from a permittee's use of a motor vehicle for which the owner of the vehicle has motor vehicle insurance coverage, the owner's motor vehicle insurance coverage is considered primary if both of the following apply:
(1) The vehicle, at the time damage occurred, was operated with the permission of the owner of the motor vehicle.
(2) The use was within the scope of the permission granted.
(c) The permittee may not recover under any other motor vehicle insurance coverage available to the permittee until the limit of all coverage provided by the owner's policy is first exhausted.
(d) In a case arising from an owner's use of a motor vehicle for which the owner of the vehicle has motor vehicle insurance coverage, the owner's motor vehicle insurance policy is considered primary for any claim made by a passenger in the motor vehicle.
(e) A passenger in a motor vehicle at the time a case described in subsection (b) or (d) arises may not recover under any other motor vehicle insurance coverage available to the passenger until the limit of all coverage available to the passenger under the owner's motor vehicle insurance policy is first exhausted.

IC 27-8-9-8
Repealed
(Repealed by P.L.226-1993, SEC.8.)
IC 27-8-9-9
Leased motor vehicles; leased vehicles used in transportation for hire

Sec. 9. (a) When a claim arises from the operation of a motor vehicle leased under a written lease agreement, if under the agreement the lessee agrees to provide coverage for damage resulting from his operation of the vehicle, then the motor vehicle insurance coverage of the lessee is primary. No claim may be made against any coverage available for the vehicle by the lessor until the limits of the motor vehicle insurance coverage provided by the lessee for the vehicle are exhausted.

(b) When a claim arises from the operation of a motor vehicle that is used in the business of transporting property for hire and leased under a written lease agreement, if under the agreement the lessor and lessee agree as to which coverage of the parties' motor vehicle insurance is primary coverage, then the policy of insurance providing that coverage is primary and no claim may be made against any other coverage for the vehicle until the limits of that policy are exhausted.


IC 27-8-9-10
Garage liability policy as owner's only coverage; permittee's coverage primary

Sec. 10. (a) This section applies if the only motor vehicle insurance coverage provided by the owner of the motor vehicle is under a garage liability policy.

(b) Notwithstanding section 7 of this chapter, any coverage available to the permittee is primary.

(c) Recovery may not be made under the garage liability policy until the limits of all coverage available to the permittee have been exhausted.


IC 27-8-9-11
Bailee's coverage primary

Sec. 11. (a) This section applies to a motor vehicle while under the control of either of the following:

(1) A bailee.

(2) An agent or employee of a bailee.

(b) As used in this section, "bailee" refers only to a person who is in the business of storing, parking, servicing, or repairing vehicles.

(c) Notwithstanding section 7 of this chapter, any coverage available to the bailee is primary.

(d) Recovery may not be made under the vehicle owner's policy until the limits of all motor vehicle insurance coverage available to the bailee have been exhausted.

IC 27-8-10
Chapter 10. Comprehensive Health Insurance

IC 27-8-10-0.1
Application of certain amendments to chapter

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


(2) The addition of sections 3.5 and 3.6 of this chapter by P.L.193-2003 applies to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(3) The amendments made to sections 2.1, 5.1, and 6 of this chapter by P.L.193-2003 apply to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.

(4) The addition of section 3.2 of this chapter by P.L.51-2004 applies to any billing that occurs on or after March 16, 2004, regardless of when the health care services to which the bill applies were provided.

As added by P.L.220-2011, SEC.440.

IC 27-8-10-0.5
Dissolution of the association

Sec. 0.5. (a) Except as provided in this section, the insurance operations of the association cease on the later of:

(1) the date on which a health benefit exchange (as defined in IC 27-19-2-8) begins operating in Indiana; or

(2) December 31, 2013.

(b) A claim for payment under an association policy must be made to the association not later than the later of:

(1) sixty (60) days after the date on which the insurance operations cease under subsection (a); or

(2) March 1, 2014.

(c) An appeal or grievance under this chapter must be resolved not later than ninety (90) days after the date on which the insurance operations cease under subsection (a).

(d) Balance billing under this chapter by a health care provider that is not a member of a health care provider network arrangement used by the association is prohibited after the later of:

(1) ninety (90) days after the date on which the insurance operations cease under subsection (a); or

(2) March 30, 2014.

(e) The association shall, not later than June 30, 2013, submit to the commissioner a plan of dissolution for the association. The following apply to a plan of dissolution submitted under this subsection:

(1) The plan of dissolution must provide for the following:

(A) Continuity of care for an individual who is covered
under an association policy and is an inpatient on the date on which the insurance operations cease under subsection (a).

(B) A final accounting described in section 2.1(g) of this chapter of the:
   (i) assessments; and
   (ii) cessation of the liability;
   of members of the association.
   (C) Resolution of any net asset deficiency.
   (D) Cessation of all liability of the association.
   (E) Final dissolution of the association.

(2) The plan of dissolution may provide that, with the approval of the board and the commissioner, a power or duty of the association may be delegated to a person that is to perform functions similar to the functions of the association.

(f) The commissioner shall, after notice and hearing, approve a plan of dissolution submitted under subsection (e) if the commissioner determines that the plan:
   (1) is suitable to ensure the fair, reasonable, and equitable dissolution of the association; and
   (2) complies with subsection (e).

(g) A plan of dissolution submitted under subsection (e) is effective upon the written approval of the commissioner.

(h) An action by or against the association must be filed not more than one (1) year after the date on which the insurance operations cease under subsection (a).

(i) This chapter expires on the date on which final dissolution of the association occurs under the plan of dissolution approved by the commissioner under subsection (f).

(j) Funds remaining in the association on the date on which final dissolution of the association occurs must be transferred into the state general fund.

(k) The association, or the person to which the association delegates powers or duties under subsection (e), may implement this section in accordance with the plan of dissolution approved by the commissioner under subsection (f).

As added by P.L.278-2013, SEC.26.

IC 27-8-10-1
Definitions
Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:
   (1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:
      (A) group health plan;
      (B) governmental plan; or
      (C) church plan;
   or health insurance coverage in connection with any of these plans;
   (2) who is not eligible for coverage under:
      (A) a group health plan;
      (B) Part A or Part B of Title XVIII of the federal Social Security Act; or
      (C) a state plan under Title XIX of the federal Social Security Act (or any successor program);
   (3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;
   (4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and
   (5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease,
pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(r) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:
   (1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
   (2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and
   (3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:
   (1) are recommended by a legally qualified physician;
   (2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and
   (3) are not primarily for the scholastic education or career and technical training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).
(w) "Policy" means a contract, policy, or plan of health insurance.
(x) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.
(y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.
(z) "Resident" means an individual who is:
   (1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or
   (2) a federally eligible individual and legally domiciled in Indiana.
(aa) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.
(bb) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.
(cc) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.
(dd) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.
(ee) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.


IC 27-8-10-2
Repealed
(Repealed by P.L.1-1990, SEC.261.)

IC 27-8-10-2.1
Comprehensive health insurance association; establishment; board of directors; plan of operation; powers and duties
Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited
service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of nine (9) members whose principal residence is in Indiana selected as follows:

(1) Four (4) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.
(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.
(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.
(4) One (1) member to be appointed by the commissioner must be a representative of health care providers.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;
(2) establish the amount and method of reimbursing members of the board;
(3) establish regular times and places for meetings of the board
of directors;
(4) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the commissioner;
(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;
(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and
(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.
(2) Subject to section 2.6 of this chapter, sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.
(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.
(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.
(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.
(6) Pool risks among members.
(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.
(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.
(9) Operate and administer any combination of plans, pools, or
other mechanisms considered appropriate to best accomplish the
fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial,
and other committees as necessary to provide technical
assistance in the operation of the association, policy and other
contract design, and any other function within the authority of
the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability
of other coverages outside the association.

(13) Provide for the use of managed care plans for insureds,
including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this
chapter.

(15) Subject to section 3 of this chapter, negotiate
reimbursement rates and enter into contracts with individual
health care providers and health care provider groups.

(f) Rates for coverages issued by the association may not be
unreasonable in relation to the benefits provided, the risk experience,
and the reasonable expenses of providing the coverage. Separate
scales of premium rates based on age apply for individual risks.
Premium rates must take into consideration the extra morbidity and
administration expenses, if any, for risks insured in the association.
The rates for a given classification must be equal to one hundred fifty
percent (150%) of the average premium rate for that class charged by
the five (5) carriers with the largest premium volume in the state
during the preceding calendar year. In determining the average rate
of the five (5) largest carriers, the rates charged by the carriers shall
be actuarially adjusted to determine the rate that would have been
charged for benefits substantially identical to those issued by the
association. All rates adopted by the association must be submitted
to the commissioner for approval.

(g) Following the close of the association's fiscal year, the
association shall determine the net premiums, the expenses of
administration, and the incurred losses for the year. Twenty-five
percent (25%) of any net loss shall be assessed by the association to
all members in proportion to their respective shares of total health
insurance premiums as reported to the department of insurance,
excluding premiums for Medicaid contracts with the state of Indiana,
received in Indiana during the calendar year (or with paid losses in
the year) coinciding with or ending during the fiscal year of the
association. Seventy-five percent (75%) of any net loss shall be paid
by the state. In sharing losses, the association may abate or defer in
any part the assessment of a member, if, in the opinion of the board,
payment of the assessment would endanger the ability of the member
to fulfill its contractual obligations. The association may also provide
for interim assessments against members of the association if
necessary to assure the financial capability of the association to meet
the incurred or estimated claims expenses or operating expenses of
the association until the association's next fiscal year is completed.
Net gains, if any, must be held at interest to offset future losses or
allocated to reduce future premiums. Assessments must be
determined by the board members specified in subsection (b)(1),
subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the
general accuracy of the financial data submitted to the association,
and the association shall have an annual audit of its operations by an
independent certified public accountant.

(i) The association is subject to examination by the department of
insurance under IC 27-1-3.1. The board of directors shall submit, not
later than March 30 of each year, a financial report for the preceding
calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in
substance to prototype forms developed by the association, must in
all other respects conform to the requirements of this chapter, and
must be filed with and approved by the commissioner before their
use.

(k) The association may not issue an association policy to any
individual who, on the effective date of the coverage applied for,
does not meet the eligibility requirements of section 5.1 of this
chapter.

(l) The association and the premium collected by the association
shall be exempt from the premium tax, the adjusted gross income tax,
or any combination of these upon revenues or income that may be
imposed by the state.

(m) Members who, during any calendar year, have paid one (1) or
more assessments levied under this chapter may include in the rates
for premiums charged for insurance policies to which this chapter
applies amounts sufficient to recoup a sum equal to the amounts paid
to the association by the member less any amounts returned to the
member insurer by the association, and the rates shall not be deemed
excessive by virtue of including an amount reasonably calculated to
recoup assessments paid by the member.

(n) The association shall provide for the option of monthly
collection of premiums.

(o) The association shall periodically certify to the budget agency
the amount necessary to pay seventy-five percent (75%) of any net
loss as specified in subsection (g).

As added by P.L.1-1990, SEC.262. Amended by P.L.26-1991,
SEC.13; P.L.192-2002(ss), SEC.169; P.L.178-2003, SEC.63;

IC 27-8-10-2.2
(Repealed by P.L.1-2007, SEC.248.)
IC 27-8-10-2.3
Reporting requirements
Sec. 2.3. (a) A member shall, not later than October 31 of each year, certify an independently audited report to the:

1. association;
2. legislative council; and
3. department of insurance;

of the amount of tax credits taken against assessments by the member under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter during the previous calendar year. A report certified under this section to the legislative council must be in an electronic format under IC 5-14-6.

(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter as of the date of the report.


IC 27-8-10-2.4
Tax credits
Sec. 2.4. (a) Beginning January 1, 2005, a member that, before January 1, 2005, has:

1. paid an assessment; and
2. not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, for each taxable year beginning after December 31, 2006, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each taxable year.

(c) If the maximum amount of a tax credit determined under subsection (b) for a taxable year exceeds a member's liability for the taxes described in subsection (b), the member may carry the unused portion of the tax credit forward to subsequent taxable years. Tax credits carried forward under this subsection are not subject to the ten percent (10%) limit set forth in subsection (b).

(d) The total amount of credits taken by a member under this section in all taxable years may not exceed the total amount of assessments paid by the member before January 1, 2005, minus the total amount of tax credits taken by the member under section 2.1 of this chapter (as in effect December 31, 2004) before January 1, 2005.

IC 27-8-10-2.5
Members; general requirements
Sec. 2.5. (a) A member shall comply with the association's plan of operation.
(b) A member assessment under section 2.1 of this chapter is due not more than thirty (30) days after the member receives written notice of the assessment. A member that pays an assessment after the due date shall pay interest on the assessment at the rate of six percent (6%) per annum.
As added by P.L.51-2004, SEC.5.

IC 27-8-10-2.6
Member and health care provider grievances
Sec. 2.6. (a) If a:
(1) member is aggrieved by an act of the association; or
(2) health care provider is aggrieved by an act of the association with respect to reimbursement to the provider under an association policy;
the member or health care provider shall, not more than ninety (90) days after the act occurs, appeal to the board of directors for review of the act.
(b) If:
(1) within thirty (30) days after an appeal is filed under subsection (a), the board of directors has not acted on the appeal; or
(2) a member or health care provider is aggrieved by a final action or decision of the board of directors;
the member or health care provider may appeal to the commissioner.
(c) An appeal to the commissioner under subsection (b) must be filed less than thirty (30) days after the:
(1) expiration of the thirty (30) day period specified in subsection (b)(1); or
(2) action or decision specified in subsection (b)(2).
(d) The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the appeal.
(e) A final action or order of the commissioner on an appeal filed under this section is subject to judicial review.
(f) If a member or health care provider sues the association, the court shall not award to the member or health care provider:
(1) attorney's fees or costs; or
(2) punitive damages.

IC 27-8-10-3
Association policy coverage; reimbursement methods; eligible expenses; managed care
Sec. 3. (a) An association policy issued under this chapter may
pay an amount for medically necessary eligible expenses related to
the diagnosis or treatment of illness or injury that exceed the
deductible and coinsurance amounts applicable under section 4 of
this chapter. Payment under an association policy must be based on
one (1) or a combination of the following reimbursement methods, as
determined by the board of directors:

1) The association's usual and customary fee schedule in effect
on January 1, 2004. If payment is based on the usual and
customary fee schedule in effect on January 1, 2004, the rates of
reimbursement under the fee schedule must be adjusted annually
by a percentage equal to the percentage change in the Indiana
medical care component of the Consumer Price Index for all
Urban Consumers, as published by the United States Bureau of
Labor Statistics during the preceding calendar year.

2) A health care provider network arrangement. If payment is
based on a health care provider network arrangement,
reimbursement under an association policy must be made
according to:

   A network fee schedule for network health care providers
   and nonnetwork health care providers; and

   any additional coinsurance that applies to the insured
   under the association policy if the insured obtains health care
   services from a nonnetwork health care provider.

3) Reimbursement for an eligible expense in an amount equal
to not less than the federal Medicare reimbursement rate for the
eligible expense plus ten percent (10%).

b) Eligible expenses are the charges for the following health care
services and articles to the extent furnished by a health care provider
in an emergency situation or furnished or prescribed by a physician:

1) Hospital services, including charges for the institution's most
common semiprivate room, and for private room only when
medically necessary, but limited to a total of one hundred eighty
(180) days in a year.

2) Professional services for the diagnosis or treatment of
injuries, illnesses, or conditions, other than mental or dental,
that are rendered by a physician or, at the physician's direction,
by the physician's staff of registered or licensed nurses, and
allied health professionals.

3) The first twenty (20) professional visits for the diagnosis or
treatment of one (1) or more mental conditions rendered during
the year by one (1) or more physicians or, at their direction, by
their staff of registered or licensed nurses, and allied health
professionals.

4) Drugs and contraceptive devices requiring a physician's
prescription.

5) Services of a skilled nursing facility for not more than one
hundred eighty (180) days in a year.

6) Services of a home health agency up to two hundred seventy
(270) days of service a year.

7) Use of radium or other radioactive materials.
(8) Oxygen.
(9) Anesthetics.
(10) Prostheses, other than dental.
(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.
(12) Diagnostic X-rays and laboratory tests.
(13) Oral surgery for:
   (A) excision of partially or completely erupted impacted teeth;
   (B) excision of a tooth root without the extraction of the entire tooth; or
   (C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
(14) Services of a physical therapist and services of a speech therapist.
(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.
(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

c) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:
   (1) establishes standards for the organization and operation of hospitals;
   (2) requires the hospital to undergo a survey process for a fee paid by the hospital; and
   (3) was organized and formed in 1951.

d) This section does not prohibit a managed care organization from using performance indicators or quality standards that:
   (1) are developed by private organizations; and
   (2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

e) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

f) The following are not eligible expenses in any association policy within the scope of this chapter:
   (1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.
   (2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens
by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

(g) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(h) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

(i) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.


IC 27-8-10-3.2
Balance billing

Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:

(1) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(2) any copayment, deductible, or coinsurance amounts applicable under the association policy.

As added by P.L.51-2004, SEC.8.
IC 27-8-10-3.5
Chronic disease and pharmaceutical management programs
Sec. 3.5. (a) The association shall:
(1) approve and implement chronic disease management and pharmaceutical management programs based on:
   (A) an analysis of the highest cost health care services covered under association policies;
   (B) a review of chronic disease management and pharmaceutical management programs used in populations similar to insureds; and
   (C) a determination of the chronic disease management and pharmaceutical management programs expected to best improve health outcomes in a cost effective manner;
(2) consider recommendations of the drug utilization review board established by IC 12-15-35-19 concerning chronic disease management and pharmaceutical management programs;
(3) when practicable, coordinate programs adopted under this section with comparable programs implemented by the state; and
(4) implement a copayment structure for prescription drugs covered under an association policy.
(b) A program approved and implemented under this section may not require prior authorization for a prescription drug that is prescribed for the treatment of:
   (1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and is included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff et seq.); or
   (2) hemophilia according to recommendations of the:
      (A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or
      (B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.
(c) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.
(d) A disease management program for which federal funding is available is considered to be approved by the association under this section.
   (e) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of coverage of treatment for the chronic disease under an association policy.

IC 27-8-10-3.6
Mail order or Internet based pharmacy
Sec. 3.6. (a) The association shall approve a mail order or Internet
based pharmacy (as defined in IC 25-26-18-1) through which an insured may obtain prescription drugs covered under an association policy.

(b) A prescription drug that is covered under an association policy is covered if the prescription drug is obtained from:
   (1) a pharmacy approved under subsection (a); or
   (2) a pharmacy that:
      (A) is not approved under subsection (a); and
      (B) agrees to sell the prescription drug at the same price as a pharmacy approved under subsection (a).

(c) A prescription drug that is:
   (1) covered under an association policy; and
   (2) obtained from a pharmacy not described in subsection (b);
   is covered for an amount equal to the price at which a pharmacy described in subsection (b) will sell the prescription drug, with the remainder of the charge for the prescription drug to be paid by the insured.


IC 27-8-10-4
Policies; deductible and coinsurance requirements; limitations
Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in accordance with this chapter must impose a five hundred dollar ($500) deductible on a per person per policy year basis. The deductible must be applied to the first five hundred dollars ($500) of eligible expenses incurred by the covered person.

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance may not exceed one thousand five hundred dollars ($1,500) per individual or two thousand five hundred dollars ($2,500) per family, per policy year.


IC 27-8-10-5
Repealed
(Repealed by P.L.1-1990, SEC.263.)

IC 27-8-10-5.1
Policies; eligible persons; dependent coverage; preexisting conditions
Sec. 5.1. (a) A person is not eligible for an association policy if the person is eligible for any of the coverage described in subdivisions (1) and (2). A person other than a federally eligible individual may not apply for an association policy unless the person has applied for:
(1) Medicaid; and
(2) coverage under the:
   (A) preexisting condition insurance plan program established
       by the Secretary of Health and Human Services under
       Section 1101 of Title I of the federal Patient Protection and
       Affordable Care Act (P.L. 111-148); and
   (B) Indiana check-up plan under IC 12-15-44.2;
not more than sixty (60) days before applying for the association policy.

(b) Except as provided in subsection (c), a person is not eligible
for an association policy if, at the effective date of coverage, the
person has or is eligible for coverage under any insurance plan that
equals or exceeds the minimum requirements for accident and
sickness insurance policies issued in Indiana as set forth in IC 27.
However, an offer of coverage described in IC 27-8-5-2.5(e) (expired
July 1, 2007, and removed), IC 27-8-5-2.7, IC 27-8-5-19.2(e)
(expired July 1, 2007, and repealed), or IC 27-8-5-19.3 does not
affect an individual's eligibility for an association policy under this
subsection. Coverage under any association policy is in excess of,
and may not duplicate, coverage under any other form of health
insurance.

(c) Except as provided in IC 27-13-16-4 and subsection (a), a
person is eligible for an association policy upon a showing that:
   (1) the person has been rejected by one (1) carrier for coverage
       under any insurance plan that equals or exceeds the minimum
       requirements for accident and sickness insurance policies issued
       in Indiana, as set forth in IC 27, without material underwriting
       restrictions;
   (2) an insurer has refused to issue insurance except at a rate
       exceeding the association plan rate; or
   (3) the person is a federally eligible individual.
For the purposes of this subsection, eligibility for Medicare coverage
does not disqualify a person who is less than sixty-five (65) years of
age from eligibility for an association policy.

(d) Coverage under an association policy terminates as follows:
   (1) On the first date on which an insured is no longer a resident
       of Indiana.
   (2) On the date on which an insured requests cancellation of the
       association policy.
   (3) On the date of the death of an insured.
   (4) At the end of the policy period for which the premium has
       been paid.
   (5) On the first date on which the insured no longer meets the
       eligibility requirements under this section.

(e) An association policy must provide that coverage of a
dependent unmarried child terminates when the child becomes
nineteen (19) years of age (or twenty-five (25) years of age if the
child is enrolled full time in an accredited educational institution).
The policy must also provide in substance that attainment of the
limiting age does not operate to terminate a dependent unmarried
child's coverage while the dependent is and continues to be both:

1. incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
2. chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(f) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (c), then an association policy may not contain provisions under which:

1. coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or
2. coverage as to a given condition is denied;
on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(i) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.


IC 27-8-10-6
Policies; renewal provisions; election to continue coverage upon death of policyholder
Sec. 6. (a) An association policy offered under this chapter must contain provisions under which the association is obligated to renew the contract until:
(1) the date on which coverage terminates under section 5.1 of this chapter; or
(2) the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the durational requirement of this subdivision.
(b) The association may not change the rates for association policies or Medicare supplement policies except on a class basis with a clear disclosure in the policy of the association's right to do so.
(c) An association policy offered under this chapter must provide that upon the death of the individual in whose name the contract is issued, every other individual then covered under the contract may elect, within a period specified in the contract, to continue coverage under the same or a different contract until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

IC 27-8-10-7
Rules; adoption
Sec. 7. The commissioner may adopt rules, under IC 4-22-2, that:
(1) provide for disclosure by carriers of the availability of insurance coverage from the association; and
(2) implement this chapter.

IC 27-8-10-8
Civil or criminal liability of association or members
Sec. 8. Neither the participation by carriers or members in the association, the establishment of rates, forms, or procedures for coverages issued by the association, nor any joint or collective action required by this chapter shall be the basis of any legal action, civil, or criminal liability against the association or members of it either jointly or separately.

IC 27-8-10-9
Medicare supplement policies
Sec. 9. (a) The association may issue Medicare supplement policies to individuals who reside in Indiana.

(b) A Medicare supplement policy issued under this section:
   (1) must be based on a model policy adopted by the commissioner under IC 27-8-13-10.1; and
   (2) must meet the standards for Medicare supplement policy benefits established under IC 27-8-13-10.1.

(c) A Medicare supplement policy issued under this section is not subject to the deductible and coinsurance requirements and the eligibility restrictions applying to association policies under sections 4 and 5.1 of this chapter. However, the association may provide that an individual is not eligible for a Medicare supplement policy issued under this section unless the individual has applied to one (1) carrier for a Medicare supplement policy and the application of the individual has been rejected. 


IC 27-8-10-10
Eligibility guidelines
Sec. 10. Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

   (1) employer;
   (2) insurance producer; or
   (3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).


IC 27-8-10-11.2
Use of diagnostic or procedure codes
Sec. 11.2. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

   (1) the association shall begin using the most current version of the:

       (A) current procedural terminology (CPT);
       (B) international classification of diseases (ICD);
       (C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
       (D) current dental terminology (CDT);
       (E) Healthcare common procedure coding system (HCPCS); and
       (F) third party administrator (TPA);

   codes under which the association pays claims for services provided under an association policy; and

   (2) a health care provider shall begin using the most current version of the:

       (A) current procedural terminology (CPT);
(B) international classification of diseases (ICD);
(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
(D) current dental terminology (CDT);
(E) Healthcare common procedure coding system (HCPCS); and
(F) third party administrator (TPA);
codes under which the health care provider submits claims for payment for services provided under an association policy.
(b) If a health care provider provides services that are covered under an association policy:
   (1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and
   (2) before the association begins using the most current version of the diagnostic or procedure code;
the association shall reimburse the health care provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.


IC 27-8-10-12
Repealed
(Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-13
Repealed
(Repealed by P.L.51-2004, SEC.10.)

IC 27-8-10-14
Repealed
(Repealed by P.L.1-2007, SEC.248.)
IC 27-8-10.1
Chapter 10.1. High Risk Indiana Check-Up Plan Participants

IC 27-8-10.1-1
"Association"
Sec. 1. As used in this chapter, "association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.
As added by P.L.218-2007, SEC.49.

IC 27-8-10.1-2
"Participant"
Sec. 2. As used in this chapter, "participant" means an individual entitled to coverage under the plan.
As added by P.L.218-2007, SEC.49.

IC 27-8-10.1-3
"Plan"
Sec. 3. As used in this chapter, "plan" refers to the Indiana check-up plan established by IC 12-15-44.2-3.

IC 27-8-10.1-4
Administration of plan for high risk participants
Sec. 4. (a) The association shall administer the plan for participants who are referred to the association by the office of the secretary of family and social services.
(b) Coverage under the plan is separate from the coverage provided under IC 27-8-10.
(c) The following apply to the administration of the plan under this chapter:
(1) Only participants referred by the office of the secretary of family and social services are eligible for plan coverage administered under this chapter.
(2) Plan coverage administered under this chapter must provide medical management services.
(d) A participant who is referred to the association under subsection (a) shall participate in medical management services provided under this chapter.
As added by P.L.218-2007, SEC.49.
IC 27-8-11
Chapter 11. Accident and Sickness Insurance—Reimbursement Agreements

IC 27-8-11-0.1
Application of certain amendments to chapter
Sec. 0.1. The addition of section 9 of this chapter by P.L.74-2007 applies to an agreement between an insurer and a provider that is entered into, amended, or renewed on or after April 26, 2007.
As added by P.L.220-2011, SEC.441.

IC 27-8-11-1
Definitions
Sec. 1. (a) The definitions in this section apply throughout this chapter.
(b) "Credentialing" means a process through which an insurer makes a determination:
   (1) based on criteria established by the insurer; and
   (2) concerning whether a provider is eligible to:
      (A) provide health care services to an insured; and
      (B) receive reimbursement for the health care services; under an agreement entered into between the provider and the insurer under section 3 of this chapter.
(c) "Health care services":
   (1) means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization; and
   (2) includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.
(d) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.
(e) "Insurer" means an insurance company authorized in this state to issue policies that provide reimbursement for expenses of health care services.
(f) "Person" means an individual, an agency, a political subdivision, a partnership, a corporation, an association, or any other entity.
(g) "Preferred provider plan" means an undertaking to enter into agreements with providers relating to terms and conditions of reimbursements for the health care services of insureds, members, or enrollees relating to the amounts to be charged to insureds, members, or enrollees for health care services.
(h) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

IC 27-8-11-2
Conflicting provisions
Sec. 2. To the extent of any conflict between this chapter and IC 27-4-1-4, IC 27-8-5-15, IC 27-8-6-1, or any other statutory provision, this chapter prevails over the conflicting provision. Agreements may be entered into under section 3(a)(1) of this chapter notwithstanding any contradictory policy provision prescribed under IC 27-8-5-3(a)(9).


IC 27-8-11-3
Reimbursement agreements; immunity

Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and
(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

e) No cause of action shall arise against any person or insurer for:
   (1) disclosing information as required by this section; or
   (2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person, provider, or insurer.

f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).


IC 27-8-11-3.1
Repealed
   (Repealed by P.L.1-1999, SEC.60.)

IC 27-8-11-4
Accessibility and availability terms; reasonable standards
Sec. 4. Policies issued under section 3(a)(3) or section 3.1 of this chapter (before its repeal) may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured. The commissioner of insurance may, under IC 4-22-2, adopt rules binding upon insurers prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies described in section 3(a)(3) or section 3.1 of this chapter (before its repeal).

IC 27-8-11-4.5
Permitted disclosures by providers; coverage of benefit or service; payment of provider; application
Sec. 4.5. (a) An agreement between an insurer and provider under section 3 of this chapter (before its repeal) may not prohibit a provider from disclosing:
   (1) financial incentives to the provider;
   (2) all treatment options available to an insured, including those not covered by the insured's policy.

(b) An insurer may not penalize a provider financially or in any other manner for making a disclosure permitted under subsection (a).

(c) An insured is not entitled to coverage of a benefit or service under a health insurance policy unless that benefit or service is
included in the insured's health insurance policy.

(d) A provider is not entitled to payment under a policy for benefits or services provided to an insured unless the provider has a contract or an agreement with the insurer.

(e) This section applies to a contract entered, renewed, or modified after June 30, 1996.


IC 27-8-11-5
Preferred provider plans; filing sworn statement

Sec. 5. Each person that organizes a preferred provider plan under this chapter shall file with the commissioner before March 1 of each year a statement, under oath, upon a form prescribed by the commissioner that covers the preceding calendar year and includes the following:

1. The name and address of each person that has organized a preferred provider plan.
2. The names and addresses of the providers with whom the preferred provider plan has entered into agreements under section 3 of this chapter.
3. The geographical area, by counties, within which the preferred provider plan provides or arranges for health care services for insureds, members or enrollees.
4. The number of insureds, members or enrollees covered by the agreements listed in subdivision (2).

As added by P.L.31-1988, SEC.23.

IC 27-8-11-6
Preferred provider plans; hospital accreditation

Sec. 6. (a) A preferred provider plan may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

1. Establishes standards for the organization and operation of hospitals;
2. Requires the hospital to undergo a survey process for a fee paid by the hospital; and
3. Was organized and formed in 1951.

(b) This section does not prohibit a preferred provider plan from using performance indicators or quality standards that:

1. Are developed by private organizations; and
2. Do not rely upon a survey process for a fee charged to the hospital to evaluate performance.


IC 27-8-11-7
Provider credentialing

Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The department of insurance shall prescribe the credentialing
application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and
(2) an insurer that performs credentialing activities.

(c) An insurer shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the insurer receives the completed credentialing application form.

(d) An insurer shall notify a provider concerning the status of the provider's completed credentialing application not later than:
   (1) sixty (60) days after the insurer receives the completed credentialing application form; and
   (2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.


IC 27-8-11-8
Provider directories

Sec. 8. (a) An insurer may provide to an insured in electronic or paper form a directory of providers with which the insurer has entered into an agreement under section 3 of this chapter.

(b) An insurer that provides a directory described in subsection (a) shall:
   (1) inform the insured that the insured may request the directory in paper form; and
   (2) provide the directory in paper form upon the request of the insured.

As added by P.L.125-2005, SEC.5.

IC 27-8-11-9
Preferred provider agreement prohibitions

Sec. 9. (a) As used in this section, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.
(2) A person that pays or administers claims on behalf of an insurer.

(b) An agreement between an insurer and a provider under this chapter may not contain a provision that:
   (1) prohibits, or grants the insurer an option to prohibit, the provider from contracting with another insurer to accept lower payment for health care services than the payment specified in the agreement;
   (2) requires, or grants the insurer an option to require, the provider to accept a lower payment from the insurer if the provider agrees with another insurer to accept lower payment for health care services;
   (3) requires, or grants the insurer an option of, termination or renegotiation of the agreement if the provider agrees with
another insurer to accept lower payment for health care services; or
(4) requires the provider to disclose the provider's reimbursement rates under contracts with other insurers.
(c) A provision that:
(1) is contained in an agreement between an insurer and a provider under this chapter; and
(2) violates this section;
is void.
As added by P.L.74-2007, SEC.1.

IC 27-8-11-10
Coverage for dialysis treatment
Sec. 10. (a) As used in this section, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider provides dialysis treatment.
(b) As used in this section, "contracted dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under section 3 of this chapter.
(c) Notwithstanding section 1 of this chapter, as used in this section, "insured" refers only to an insured who requires dialysis treatment.
(d) As used in this section, "insurer" includes the following:
(1) An administrator licensed under IC 27-1-25.
(2) An agent of an insurer.
(e) As used in this section, "non-contracted dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under section 3 of this chapter.
(f) An insurer shall not require an insured, as a condition of coverage or reimbursement, to:
(1) if the nearest dialysis facility is located within thirty (30) miles of the insured's home, travel more than thirty (30) miles from the insured's home to obtain dialysis treatment; or
(2) if the nearest dialysis facility is located more than thirty (30) miles from the insured's home, travel a greater distance than the distance to the nearest dialysis facility to obtain dialysis treatment;
regardless of whether the insured chooses to receive dialysis treatment at a contracted dialysis facility or a non-contracted dialysis facility.

IC 27-8-11-11
Insurer payment to insured for service rendered by noncontracted provider; requirements
Sec. 11. (a) As used in this section, "noncontracted provider" means a provider that has not entered into an agreement with an insurer under section 3 of this chapter.
(b) After September 30, 2009, if an insurer makes a payment to an insured for a health care service rendered by a noncontracted
provider, the insurer shall include with the payment instrument written notice to the insured that includes the following:

1. A statement specifying the claims covered by the payment instrument.
2. The name and address of the provider submitting each claim.
3. The amount paid by the insurer for each claim.
4. Any amount of a claim that is the insured's responsibility.
5. A statement in at least 24 point bold type that:
   A) instructs the insured to use the payment to pay the noncontracted provider if the insured has not paid the noncontracted provider in full;
   B) specifies that paying the noncontracted provider is the insured's responsibility; and
   C) states that the failure to make the payment violates the law and may result in collection proceedings or criminal penalties.

As added by P.L.144-2009, SEC.2.
IC 27-8-12
Chapter 12. Long Term Care Insurance

IC 27-8-12-1
"Applicant" defined
Sec. 1. As used in this chapter, "applicant" means:
(1) an individual who applies for long term care insurance
through an individual insurance policy; or
(2) a prospective holder of a certificate issued under a group
long term care insurance policy.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-2
"Certificate" defined
Sec. 2. As used in this chapter, "certificate" means a document
issued to a member of the group covered under a group insurance
policy, which policy has been delivered or issued for delivery in Indiana, to signify that the individual named in the certificate is covered under the policy.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-3
"Certificate holder" defined
Sec. 3. As used in this chapter, "certificate holder" means an individual to whom a certificate is issued.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-4
"Insurance policy" defined
Sec. 4. As used in this chapter, "insurance policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in Indiana by an insurer, a fraternal benefit society, a nonprofit corporation, a health maintenance organization (as defined in IC 27-13-1-19), a limited service health maintenance organization (as defined in IC 27-13-34-4), a preferred provider arrangement, or any other organization.

IC 27-8-12-4.5
"Long term care facility" defined
Sec. 4.5. As used in this chapter, "long term care facility" has the meaning set forth in IC 12-15-39.6-2.

IC 27-8-12-5
"Long term care insurance policy" defined
Sec. 5. (a) As used in this chapter, "long term care insurance policy" means an insurance policy providing coverage for at least twelve (12) consecutive months for each covered person on an
expense incurred, indemnity, prepaid, or other basis for one (1) or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care wing of a hospital.

(b) The term includes the following:
   (1) A policy advertised, marketed, or offered as long term care insurance.
   (2) A group or individual annuity, a life insurance policy, or riders that provide directly or supplement long term care insurance.
   (3) A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(c) The term does not include the following:
   (1) An insurance policy that is offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, comprehensive coverage, catastrophic coverage, or limited benefit health coverage.
   (2) A life insurance policy that accelerates the death benefit specifically for terminal illness, a medical condition requiring extraordinary medical intervention, or a permanent institutional confinement, and that provides the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care.
   (3) An insurance policy that is offered primarily to provide basic Medicare supplemental coverage (as defined under IC 27-8-13).


IC 27-8-12-6
Compliance with statutory requirements
Sec. 6. An insurance policy may be marketed, advertised, offered, or sold in Indiana as long term care insurance only if that policy complies with the requirements of this chapter.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-7
Policy disclosure standards; marketing practices; continuing education; penalties; reporting practices; rules
Sec. 7. (a) The insurance commissioner shall adopt rules under IC 4-22-2 establishing standards of full and fair disclosure concerning long term care insurance policies. The standards must require disclosure of information concerning the following:
   (1) The sale of the policies.
   (2) Terms of renewability.
   (3) Initial and subsequent terms of eligibility.
   (4) Nonduplication of coverage provisions.
(5) Coverage of dependents.
(6) Preexisting conditions.
(7) Termination of insurance coverage.
(8) Probationary periods.
(9) Limitations on coverage.
(10) Exceptions to coverage.
(11) Reductions from coverage.
(12) Elimination periods.
(13) Requirements for replacement.
(14) Recurrent conditions.
(15) Definitions of terms.
(16) Continuation or conversion of coverage.

(b) The insurance commissioner shall adopt rules under IC 4-22-2 to establish minimum standards concerning:

1. marketing practices;
2. insurance producer continuing education;
3. penalties; and
4. reporting practices;

for long term care insurance.

(c) Rules adopted by the insurance commissioner under this section must:

1. recognize the unique, developing, and experimental nature of long term care insurance; and
2. where necessary or appropriate, recognize the distinctions between group insurance policies and individual insurance policies.


IC 27-8-12-7.1
Qualification of long term care policies; rules

Sec. 7.1. The department of insurance shall adopt rules under IC 4-22-2 that establish standards for the qualification of a long term care policy under IC 12-15-39.6. The rules must include the following:

1. The standards adopted under section 7 of this chapter.
2. The requirement that an insurer or other person who issues a qualified long term care policy must at a minimum offer to each policyholder or prospective policyholder a policy that provides both:
   (A) long term care facility coverage; and
   (B) home and community care coverage.
3. A provision that an insurer or other person who complies with subdivision (2) may elect to also offer a qualified long term care policy that provides only long term care facility coverage.
4. The submission of data by insurers that will allow the department of insurance, the office of Medicaid policy and planning, and the division of aging to administer the Indiana long term care program under IC 12-15-39.6.
5. Other standards needed to administer the Indiana long term
IC 27-8-12-8
Loss ratio standards rule
Sec. 8. The insurance commissioner may not adopt a rule establishing loss ratio standards that apply to long term care insurance policies unless the rule exclusively concerns long term care insurance.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-9
Termination of policy on grounds of age or deteriorated health
Sec. 9. An insurer that issues a long term care insurance policy may not cancel, decline to renew, or otherwise terminate the policy solely on the grounds of the age or deterioration in mental or physical health of the insured individual or certificate holder.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-10
"Preexisting condition" defined; exclusion of coverage; limitations
Sec. 10. (a) As used in this section, "preexisting condition" means the existence of:
(1) either:
   (A) symptoms that would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or
   (B) a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services; within
(2) a period not to exceed either:
   (A) twelve (12) months preceding the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or
   (B) twenty-four (24) months preceding the effective date of coverage of an insured person who is less than sixty-five (65) years of age on the effective date of coverage.
(b) A long term care insurance policy may exclude coverage for a loss or confinement that is the result of a preexisting condition only if that loss or confinement begins within:
(1) twelve (12) months following the effective date of coverage of an insured person who is sixty-five (65) years of age or older on the effective date of coverage; or
(2) twenty-four (24) months following the effective date of coverage of an insured person who is under sixty-five (65) years of age on the effective date of coverage.
(c) The insurance commissioner may extend the limitation periods set forth in subsections (a)(2)(A), (a)(2)(B), and (b), concerning
specific age group categories in specific policies upon a finding that
the extension is in the best interest of the public.

As added by P.L.275-1987, SEC.1.

IC 27-8-12-10.5
Loss or confinement resulting from a preexisting condition;
exclusion of coverage; limitation period; rules

Sec. 10.5. (a) As used in this section, "preexisting condition"
means a condition for which medical advice or treatment was
recommended by or received from a provider of health care services
within six (6) months preceding the effective date of coverage of an
insured individual.

(b) A long term care insurance policy may not use a definition of
preexisting condition that is more restrictive than the definition
contained in subsection (a).

(c) Except for a group long term care policy under
IC 27-8-5-16(1) or IC 27-1-12-37, a long term care insurance policy
may not exclude coverage for a loss or confinement that is the result
of a preexisting condition unless the loss or confinement begins
within six (6) months following the effective date of coverage of an
insured individual.

(d) The commissioner may extend the limitation period under
subsections (a) and (c) concerning a specific age group category in
a specific policy form upon a finding by the commissioner that the
extension is in the best interest of the public.

(e) This section does not prohibit an insurer from doing any of the
following:

(1) Using an application form designed to elicit the complete
health history of an applicant.

(2) Based on an application, underwriting in accordance with
the insurer's established underwriting standards.

(f) Unless otherwise provided in the policy or certificate, a
preexisting condition, regardless of whether the condition is disclosed
on the application, need not be covered until after the waiting period
described in subsection (c).

(g) A long term care insurance policy may not exclude or use a
waiver or rider to exclude, limit, or reduce coverage or benefits for
a specifically named or described preexisting disease or physical
condition beyond the waiting period described in subsection (c).


IC 27-8-12-10.6
Conditions on eligibility for benefits; restrictions

Sec. 10.6. (a) A long term care insurance policy may not be
delivered or issued for delivery in Indiana if the policy:

(1) conditions eligibility for any benefits on a prior
hospitalization requirement;

(2) conditions eligibility for benefits provided in an institutional
care setting on the receipt of a higher level of institutional care;
or
(3) conditions eligibility for a benefit other than:
   (A) a waiver of premium;
   (B) postconfinement;
   (C) postacute care; or
   (D) recuperative benefits;
   on a prior institutionalization requirement.
(b) A long term care insurance policy containing a postconfinement, postacute, or recuperative benefit must clearly label in a separate paragraph of the policy a statement entitled "limitations or conditions on eligibility for benefits". Under the statement, the policy must outline any limitations or conditions for benefits.
(c) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care must not require a prior institutional stay of more than thirty (30) days.
(d) A long term care insurance policy or rider that provides benefits only following institutionalization may not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.


IC 27-8-12-11
Establishment of new waiting period
Sec. 11. (a) A long term care insurance policy may not:
(1) contain a provision establishing a new waiting period if an existing policy is converted to or replaced by a new form issued by the same insurer, except in the case of an increase in benefits voluntarily selected by the insured individual or group policyholder;
(2) be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;
(3) provide coverage for skilled nursing care only; or
(4) provide significantly more coverage for skilled care than coverage for a lower level of care.
(b) Subsection (a) does not prohibit an insurer from voluntarily waiving any authorized waiting period.


IC 27-8-12-12
No obligation return period; notice
Sec. 12. (a) An individual long term care insurance policyholder may return the policy within thirty (30) days of its delivery and have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.
(b) Each individual long term care insurance policy must have prominently printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).
IC 27-8-12-13
Direct response solicitation issued policies; no obligation return period; notice

Sec. 13. (a) A person insured under a long term care insurance policy or certificate issued under a direct response solicitation may return the policy or certificate within thirty (30) days of its delivery and have the premium refunded if the insured person is not satisfied for any reason.

(b) Each long term care insurance policy or certificate issued under a direct response solicitation must have printed on, or attached to, its first page a notice setting forth in substance the provisions of subsection (a).

As added by P.L.275-1987, SEC.1.

IC 27-8-12-14
Outline of coverage; contents

Sec. 14. (a) The insurer shall deliver an outline of the coverage provided by an individual long term care insurance policy to the prospective applicant at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and the document's purpose.

(b) The commissioner shall prescribe a standard format regarding:

(1) style;
(2) arrangement;
(3) overall appearance; and
(4) content;

for an outline of coverage.

(c) An insurance producer who solicits a long term care insurance policy shall deliver the outline of coverage before the presentation of an application or enrollment form.

(d) The outline of coverage must be presented in conjunction with any application or enrollment form when there is a direct response solicitation of long term care insurance.

(e) An outline of coverage required under this section must include the following:

(1) A description of the principal benefits and coverage provided in the policy.
(2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.
(3) A statement of the policy's renewal provisions, including any reservation by the insurer of a right to change premiums.
(4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine the exact terms of the coverage provided by the policy.
(5) A description of the terms under which the policy may be returned and the premium refunded.
A brief description of the relationship of the cost of care and benefits.

A statement of the terms under which the policy or certificate may continue or be discontinued, including any reservation in the policy of the right to change the premium.

A specific statement of the provisions for continuation or conversion of group coverage.


IC 27-8-12-14.5
Policy summary; requirements
Sec. 14.5. (a) A policy summary shall be delivered, at the time of policy delivery, for an individual life insurance policy that provides long term care benefits within the policy or by a rider.

(b) The insurer shall deliver the policy summary upon the applicant's request when there is a direct response solicitation. If there is no request, the insurer shall deliver the policy summary not later than when the policy is delivered.

(c) The policy summary must include the following:

1. An explanation of how long a long term care benefit interacts with other components of the policy, including deductions from a death benefit.

2. An illustration of the amount of a benefit, the length of a benefit, and the guaranteed lifetime benefits for each covered person.

3. Any exclusion, reduction, and limitation on benefits of long term care.

(d) A policy summary required under this section must also include the following information if applicable:

1. A disclosure of any effect of exercising rights under the policy other than rights referred to in subsection (c).

2. A disclosure of any guarantee related to long term care costs of insurance charges.


IC 27-8-12-14.6
Benefits funded through life insurance by acceleration of death benefits; benefit payment status report; contents
Sec. 14.6. If a long term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report containing the following shall be provided to the policyholder:

1. Any long term care benefit paid out during the month.

2. An explanation of any change in the policy, including a change in death benefit or cash value due to long term care benefits being paid.

3. The amount of long term care benefits remaining under the policy.
IC 27-8-12-15
Group policy certificate; contents
Sec. 15. A certificate issued under a group long term care insurance policy that is delivered or issued for delivery in Indiana must include the following:
(1) A description of the principal benefits and coverage provided in the policy.
(2) A statement of the principal exclusions, reductions, and limitations set forth in the policy.
(3) A statement that the group master policy should be consulted to determine the exact terms of the coverage provided by the policy.
As added by P.L.275-1987, SEC.1.

IC 27-8-12-16
Application of general insurance law
Sec. 16. All other applicable provisions of IC 27 not in conflict with the provisions of this chapter apply to insurance policies issued under this chapter. A long term care insurance policy issued under this chapter is not subject to any rule adopted under IC 27-1-3-7(c).
As added by P.L.275-1987, SEC.1.

IC 27-8-12-17
Group policies issued in another state; requirements
Sec. 17. Group long term care insurance may not be offered to a resident of Indiana under a group policy issued in another state unless the commissioner determines that the group long term care insurance policy substantially complies with insurance requirements similar to those established under this chapter.

IC 27-8-12-18
Insurance producer commissions
Sec. 18. (a) An insurer or other entity that provides a commission to an insurance producer or other representative for the sale of a long term care insurance policy may not violate the following conditions:
(1) The insurer or other entity shall, for at least six (6) years, pay to the insurance producer or other representative an annual commission for selling or servicing the policy.
(2) The amount of commission provided in years after the first year must be determined based on the premium charged for the long term care insurance policy during the first year.
(b) If an existing long term care policy or certificate is replaced, the insurer or other entity that issues the replacement policy may not provide, and its insurance producer may not accept, a commission in an amount greater than the renewal commission payable by the replacing insurer on renewal policies, unless the benefits of the replacement policy or certificate are clearly and substantially greater
than the benefits under the replaced policy or certificate.

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

(1) Life insurance policies and certificates.

(2) A policy or certificate that is sponsored by an employer for the benefit of:

   (A) the employer's employees; or

   (B) the employer's employees and their dependents.


**IC 27-8-12-19**

**Violations; civil penalty; amount**

Sec. 19. (a) In addition to any other sanction provided under this article, the commissioner may impose a civil penalty against an insurer who has violated this chapter or rules adopted under this chapter. A penalty imposed under this section must be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) ten thousand dollars ($10,000).

(b) In addition to any other sanction provided under this title, the commissioner may impose a penalty against an insurance producer who has violated this chapter or rules adopted under this chapter. The penalty must be the greater of:

(1) up to three (3) times the amount of the commissions paid to that insurance producer for each policy involved in the violation; or

(2) twenty-five hundred dollars ($2,500).

IC 27-8-13
Chapter 13. Medicare Supplement Insurance Solicitations

IC 27-8-13-0.1
Application of certain amendments to chapter
Sec. 0.1. The addition of section 10.1 of this chapter by P.L.195-1991 applies only to policies issued after December 31, 1991.
As added by P.L.220-2011, SEC.442.

IC 27-8-13-1
"Medicare" defined
Sec. 1. As used in this chapter, "medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).
As added by P.L.275-1987, SEC.2.

IC 27-8-13-2
"Medicare supplement insurance solicitation" defined
Sec. 2. As used in this chapter, "Medicare supplement insurance solicitation" means a meeting between an insurance producer and another individual at which the insurance producer discusses the possible issuance of a medicare supplement policy to the other individual.

IC 27-8-13-3
"Medicare supplement policy" defined
Sec. 3. (a) As used in this chapter, "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health maintenance organizations that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare benefits.
   (b) The term does not include a group policy issued:
      (1) to or for the benefit of employees;
      (2) to one (1) or more labor organizations; or
      (3) to the trustees of a fund established:
         (A) by one (1) or more employees or former employees; or
         (B) for members or former members of a labor organization.
   (c) The term does not include:
      (1) a policy issued under a contract under Section 1876 or 1833 of the federal Social Security Act (42 U.S.C. 1395 et seq.); or
      (2) a policy issued under a demonstration project authorized under amendments to the federal Social Security Act.

IC 27-8-13-4
Receipt for materials received by soliciting insurance producer;
"materials" defined
Sec. 4. (a) Following a Medicare supplement insurance solicitation, an insurance producer shall give the individual involved in the solicitation a receipt for materials received by the insurance producer as a result of the solicitation.

(b) The receipt required under subsection (a) must be dated and signed by the insurance producer and must set forth the following:

1. An itemized list of the materials received by the insurance producer.
2. The insurance producer's name.
3. The address and telephone number of the insurance producer's office.

(c) As used in this section, "materials" includes any:

1. document;
2. cash;
3. money order; or
4. check or draft;

received by the insurance producer. The term does not include an application for a policy.


IC 27-8-13-5
"Applicant" defined
Sec. 5. As used in this chapter, "applicant" means:

1. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
2. in the case of a group Medicare supplement policy, the proposed certificate holder.


IC 27-8-13-6
"Certificate" defined
Sec. 6. As used in this chapter, "certificate" means a certificate:

1. issued under a group Medicare supplement policy; and
2. delivered or issued for delivery in Indiana.

As added by P.L.255-1989, SEC.3.

IC 27-8-13-6.2
"Certificate form" defined
Sec. 6.2. As used in this chapter, "certificate form" means the form on which a certificate is delivered or issued for delivery by the issuer.


IC 27-8-13-7
(Repealed by P.L.126-1992, SEC.17.)

IC 27-8-13-7.3
"Issuer" defined
Sec. 7.3. As used in this chapter, "issuer" includes:
   (1) an insurance company;
   (2) a fraternal benefit society;
   (3) a health care service plan;
   (4) a health maintenance organization; and
   (5) any other entity;
that delivers a Medicare supplement policy or certificate in Indiana or issues a Medicare supplement policy or certificate for delivery in Indiana.

IC 27-8-13-7.6
"Policy form" defined
Sec. 7.6. As used in this chapter, "policy form" means the form on which a policy is delivered or issued for delivery by the issuer.
As added by P.L.126-1992, SEC.5.

IC 27-8-13-8
Application of chapter
Sec. 8. (a) Except as otherwise specifically provided, this chapter applies to the following:
   (1) All Medicare supplement policies delivered or issued for delivery in Indiana on or after June 1, 1989.
   (2) All certificates issued under group Medicare supplement policies that have been delivered or issued for delivery in Indiana.
   (b) This chapter does not apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.

IC 27-8-13-9
Medicare supplement policies; standards; preexisting medical conditions
Sec. 9. (a) A Medicare supplement policy, contract, or certificate in force in Indiana may not contain benefits that duplicate benefits provided by Medicare. However, a change in Medicare coverage that becomes effective after a Medicare supplement policy, contract, or certificate is in force in Indiana and that causes a duplication of benefits does not void the policy, contract, or certificate.
   (b) The commissioner shall adopt rules under IC 4-22-2 to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with Indiana law. No requirement of IC 27 relating to minimum required policy benefits other than the minimum standards contained in this chapter apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:
(1) terms of renewability;
(2) initial and subsequent conditions of eligibility;
(3) nonduplication of coverage;
(4) probationary periods;
(5) benefit limitations, exceptions, and reductions;
(6) elimination periods;
(7) requirements for replacement;
(8) recurrent conditions; and
(9) definitions of terms.

(c) The commissioner may adopt rules under IC 4-22-2 that specify prohibited policy provisions not specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to a person insured or proposed to be insured under a Medicare supplement policy or certificate.

(d) Notwithstanding any other law, a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six (6) months after the effective date of the policy because the loss involves a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.


IC 27-8-13-10
Medicare supplement policy and certificate standards; conformity with federal law and regulations

Sec. 10. (a) The commissioner shall adopt rules under IC 4-22-2 to establish minimum standards for:

(1) claims payment;
(2) marketing practices;
(3) compensation arrangements; and
(4) reporting practices;

for Medicare supplement policies and certificates.

(b) The commissioner may adopt rules under IC 4-22-2 that are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and federal regulations. A rule adopted under this subsection may do the following:

(1) Require refunds or credits if the policies or certificates do not meet loss ratio requirements.
(2) Establish a uniform methodology for calculating and reporting loss ratios.
(3) Assure public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.
(4) Establish a process for approving or disapproving policy forms and certificate forms and proposed premium increases.
(5) Establish a policy for holding public hearings before approval of premium increases.
(6) Establish standards for Medicare Select policies and
Model Medicare supplement policy standards

Sec. 10.1. (a) The commissioner shall adopt rules under IC 4-22-2 to establish standards for model Medicare supplement policies. The standards must include standards for benefits.

(b) An insurer may issue a Medicare supplement policy or certificate in Indiana only if the policy or certificate is one (1) of the model policies adopted by the department under subsection (a).

Reasonable benefits; loss ratio standards

Sec. 12. (a) Medicare supplement policies must return to policyholders benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt rules under IC 4-22-2 to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses if coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Outline of coverage; contents

Sec. 14. (a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in Indiana unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe by rule adopted under IC 4-22-2 the form and content of the outline of coverage required by subsection (a). For purposes of this section, "form" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage must include the following:
(1) A description of the principal benefits and coverage provided in the policy.
(2) A statement of the renewal provisions, including a reservation by the issuer of a right to change premiums, and a disclosure of the existence of any automatic premium increases based on the policyholder's age.
(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.


IC 27-8-13-15

Informational brochures

Sec. 15. (a) The commissioner may prescribe by rule adopted under IC 4-22-2 a standard form and the contents of an informational brochure for persons eligible for Medicare that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.

(b) Except in the case of direct response insurance policies, the commissioner may require by rule adopted under IC 4-22-2 that the information brochure be provided to a prospective insured eligible for Medicare concurrently with delivery of the outline of coverage required under section 14 of this chapter.

(c) With respect to direct response insurance policies, the commissioner may require by rule adopted under IC 4-22-2 that the prescribed brochure be provided upon request to a prospective insured eligible for Medicare, but not later than the time of policy delivery.


IC 27-8-13-16

Disclosures distinguishing Medicare supplement coverages from accident and sickness coverages

Sec. 16. (a) The commissioner may adopt rules under IC 4-22-2 for captions or notice requirements that are determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages. The captions or notice requirements may apply to all accident and sickness insurance policies sold to persons eligible for Medicare by reason of age, other than:

(1) Medicare supplement policies;
(2) disability income policies;
(3) basic, catastrophic, or major medical expense policies; and
(4) single premium, nonrenewable policies.

(b) The commissioner may also adopt rules under IC 4-22-2 to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for Medicare.

IC 27-8-13-17
Return privilege notice; refund
Sec. 17. (a) Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within thirty (30) days of delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.
(b) A refund made under this section shall be paid directly to the applicant by the issuer in a timely manner.

IC 27-8-13-18
Review and approval of proposed advertisements
Sec. 18. Every issuer of Medicare supplement insurance policies or certificates in Indiana shall provide a copy of any Medicare supplement advertisement intended for use in Indiana whether through written, radio, or television medium to the commissioner for review or approval by the commissioner to the extent required under Indiana law.

IC 27-8-13-19
Penalties for noncompliance
Sec. 19. In addition to any other penalties for violations of IC 27, the commissioner may take either or both of the following actions:
(1) Require issuers violating this chapter or rules adopted under this chapter to cease marketing a Medicare supplement policy or certificate in Indiana that is related directly or indirectly to a violation.
(2) Require the issuer to take the action necessary to comply with this chapter.

IC 27-8-13-20
Refund of unused premiums
Sec. 20. (a) All Medicare supplement policies 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 provide 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).

(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.

As added by P.L.151-1990, SEC.2.
IC 27-8-13.4
Chapter 13.4. Coverage for Abortion

IC 27-8-13.4-1
Accident and sickness insurance policy; exclusions

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, Class 1(b) and Class 2(a); and
(2) is issued on a group or individual basis.
(b) As used in this chapter, "accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) 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.
As added by P.L.124-2014, SEC.1.

IC 27-8-13.4-2
Prohibition on coverage of abortion; exceptions; coverage through rider or endorsement

Sec. 2. (a) An accident and sickness insurance policy that is issued, delivered, amended, or renewed after December 31, 2014, may not provide coverage for abortion, except in the following cases:
(1) The pregnant woman became pregnant through an act of rape or incest.
(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
(b) An insurer that issues an accident and sickness insurance policy described in subsection (a) may offer coverage for abortion through a rider or an endorsement.
As added by P.L.124-2014, SEC.1.
IC 27-8-13.5
Chapter 13.5. Coverage for Medical Services for Women with High Breast Density

IC 27-8-13.5-1
Application of chapter
Sec. 1. This chapter applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2013.
As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-2
"High breast density"
Sec. 2. As used in this chapter, "high breast density" means a condition in which there is a greater amount of breast and connective tissue in comparison to fat in the breast.
As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-3
"Insured"
Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.
As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-4
"Policy of accident and sickness insurance"
Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. 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.

As added by P.L.126-2013, SEC.4.

IC 27-8-13.5-5
High breast density
Sec. 5. A policy of accident and sickness insurance must provide coverage for an appropriate medical screening, test, or examination for a female insured who is at least forty (40) years of age and who has been determined to have high breast density.

As added by P.L.126-2013, SEC.4.
IC 27-8-14
Chapter 14. Coverage for Services Related to Breast Cancer Screening

IC 27-8-14-0.1
Application of chapter; application of certain amendments to chapter

Sec. 0.1. (a) The addition of this chapter and the amendments made to IC 13-1-2-11 (before its repeal, now codified at IC 16-41-35-30) by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.

(b) The amendments made to section 6 of this chapter by P.L.170-1999 apply to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1999.

As added by P.L.220-2011, SEC.443.

IC 27-8-14-1
"Accident and sickness insurance policy"

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.

(b) 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-14-2
"Breast cancer screening mammography"
Sec. 2. (a) As used in this chapter, "breast cancer screening mammography" means a standard, two (2) view per breast, low-dose radiographic examination of the breasts that is:
(1) furnished to an asymptomatic woman; and
(2) performed by a mammography services provider using equipment designed by the manufacturer for and dedicated specifically to mammography in order to detect unsuspected breast cancer.
(b) The term includes the interpretation of the results of a breast cancer screening mammography by a physician.

IC 27-8-14-3
"Insured"
Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

IC 27-8-14-4
"Mammography services provider"
Sec. 4. As used in this chapter, "mammography services provider" means a person or facility that:
(1) has been accredited by the American College of Radiology;
(2) meets equivalent guidelines established by the state department of health; or
(3) certified by the Federal Department of Health and Human Services for participation in the Medicare program (42 U.S.C. 1395 et seq.).

IC 27-8-14-5
"Woman at risk"
Sec. 5. As used in this chapter, "woman at risk" means a woman who meets at least one (1) of the following descriptions:
(1) A woman who has a personal history of breast cancer.
(2) A woman who has a personal history of breast disease that was proven benign by biopsy.
(3) A woman whose mother, sister, or daughter has had breast cancer.
(4) A woman who is at least thirty (30) years of age and has not given birth.

IC 27-8-14-6
Breast cancer screening mammography; coverage
Sec. 6. (a) Except as provided in subsection (f), an insurer must
provide coverage for breast cancer screening mammography in any accident and sickness insurance policy that the insurer issues in Indiana.

(b) Except as provided in subsection (f), the coverage that an insurer must provide under this section must include the following:
   (1) If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.
   (2) If the insured is:
      (A) less than forty (40) years of age; and
      (B) a woman at risk;
      one (1) breast cancer screening mammography performed upon the insured every year.
   (3) If the insured is at least forty (40) years of age, one (1) breast cancer screening mammography performed upon the insured every year.
   (4) Any additional mammography views that are required for proper evaluation.
   (5) Ultrasound services, if determined medically necessary by the physician treating the insured.
(c) Except as provided in subsection (f), the coverage that an insurer must provide under this section must provide reimbursement for breast cancer screening mammography at a level at least as high as:
   (1) the limitation on payment for screening mammography services established in 42 CFR 405.534(b)(3) according to the Medicare Economic Index at the time the breast cancer screening mammography is performed; or
   (2) the rate negotiated by a contract provider according to the provisions of the insurance policy; whichever is lower.
(d) Except as provided in subsection (f), the coverage that an insurer must provide under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.
(e) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.
(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).

IC 27-8-14.1
Chapter 14.1. Coverage for Services Related to Morbid Obesity

IC 27-8-14.1-0.1
Application of certain amendments to chapter
Sec. 0.1. The amendments made to section 4 of this chapter by P.L.196-2005 apply to an accident and sickness insurance policy that is issued, delivered, amended, or renewed after June 30, 2005. As added by P.L.220-2011, SEC.444.

IC 27-8-14.1-1
"Accident and sickness insurance policy" defined
Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) As used in this chapter, "accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-14.1-2
"Health care provider" defined
Sec. 2. As used in this chapter, "health care provider" means a:
(1) physician licensed under IC 25-22.5; or
(2) hospital licensed under IC 16-21; that provides health care services for surgical treatment of morbid obesity.
As added by P.L.78-2000, SEC.2.

IC 27-8-14.1-3
"Morbid obesity" defined
Sec. 3. As used in this chapter, "morbid obesity" means:
(1) a body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
(2) a body mass index of at least forty (40) kilograms per meter squared without comorbidity.
For purposes of this section, body mass index is equal to weight in kilograms divided by height in meters squared.

IC 27-8-14.1-4
Coverage for nonexperimental, surgical treatment of morbid obesity
Sec. 4. (a) Except as provided in subsection (b), an insurer that issues an accident and sickness insurance policy shall offer coverage for nonexperimental, surgical treatment by a health care provider of morbid obesity:
(1) that has persisted for at least five (5) years; and
(2) for which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least six (6) consecutive months.
(b) An insurer that issues an accident and sickness insurance policy may not provide coverage for a surgical treatment of morbid obesity for an insured who is less than twenty-one (21) years of age unless two (2) physicians licensed under IC 25-22.5 determine that the surgery is necessary to:
(1) save the life of the insured; or
(2) restore the insured's ability to maintain a major life activity (as defined in IC 4-23-29-6);
and each physician documents in the insured's medical record the reason for the physician's determination.
IC 27-8-14.2
Chapter 14.2. Insurance Coverage for Pervasive Developmental Disorders

IC 27-8-14.2-1
"Accident and sickness insurance policy" defined
Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
      (A) may not be renewed; and
      (B) has a duration of not more than six (6) months.
   (7) 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.
   (8) A supplemental plan that always pays in addition to other coverage.
   (9) A student health plan.
   (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.


IC 27-8-14.2-2
"Insured" defined
Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.


IC 27-8-14.2-3
"Autism spectrum disorder"
Sec. 3. As used in this chapter, "autism spectrum disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
IC 27-8-14.2-4
Group coverage required
Sec. 4. (a) An accident and sickness insurance policy that is issued on a group basis must provide coverage for the treatment of an autism spectrum disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with an autism spectrum disorder.
(b) The coverage required under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.

IC 27-8-14.2-5
Individual coverage required
Sec. 5. (a) An insurer that issues an accident and sickness insurance policy on an individual basis must offer to provide coverage for the treatment of an autism spectrum disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with an autism spectrum disorder.
(b) The coverage that must be offered under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.
IC 27-8-14.5
Chapter 14.5. Coverage for Services Related to Diabetes

IC 27-8-14.5-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.190-1997 applies to all health insurance plans issued or renewed after December 31, 1997.

IC 27-8-14.5-1
"Health insurance plan" defined
Sec. 1. (a) As used in this chapter, "health insurance plan" means any:
(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to an insured.
(b) 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-14.5-2
"Insured" defined
Sec. 2. As used in this chapter, "insured" refers to an individual with:
(1) insulin-using diabetes;
(2) non-insulin using diabetes; or
(3) elevated blood glucose levels induced by pregnancy or another medical condition;
who is covered by a health insurance plan issued by an insurer.
As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-3
"Insurer" defined
Sec. 3. As used in this chapter, "insurer" means any person who provides health insurance and issues health insurance plans in Indiana. The term includes the following:
(1) A licensed insurance company.
(2) A prepaid hospital or medical service plan.
(3) A health maintenance organization.
(4) A state employee health benefit plan.
(5) The state Medicaid plan.
(6) Any person providing a plan of health insurance subject to state insurance law.
As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-4
Coverage for treatments, supplies, and equipment
Sec. 4. A health insurance plan issued by an insurer must provide coverage to the insured for the medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29, subject to the general provisions of the health insurance plan.
As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-5
Deductible, copayment, and coinsurance provisions
Sec. 5. (a) An insured may not be required to pay an annual deductible or copayment that is greater than an annual deductible or copayment established for similar benefits under the health insurance plan. If the plan does not cover a similar benefit, the copayment or deductible may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.
(b) An insured may be subject to coinsurance that is not greater than coinsurance established for similar benefits under the health insurance plan. If the plan does not cover a similar benefit, the coinsurance may not be set at a level that materially diminishes the value of the diabetes benefit required by this chapter.
As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-6
Coverage for diabetes self-management training
Sec. 6. (a) A health insurance plan issued by an insurer must provide coverage for diabetes self-management training that is:
(1) medically necessary;
(2) ordered in writing by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29; and
(3) provided by a health care professional who:
   (A) is licensed, registered, or certified under IC 25; and
   (B) has specialized training in the management of diabetes.
(b) Coverage for diabetes self-management training may be limited to the following:
   (1) One (1) or more visits after receiving a diagnosis of diabetes.
   (2) One (1) or more visits after receiving a diagnosis by a physician licensed under IC 25-22.5 or a podiatrist licensed under IC 25-29 that:
      (A) represents a significant change in the insured's symptoms or condition; and
      (B) makes changes in the insured's self-management medically necessary.
   (3) One (1) or more visits for reeducation or refresher training.
(c) Coverage for diabetes self-management training is subject to the requirements of the health insurance plan regarding the use of participating providers.
As added by P.L.190-1997, SEC.1.

IC 27-8-14.5-7
Adoption of rules
   Sec. 7. The department may adopt rules under IC 4-22-2 to carry out this chapter.
As added by P.L.190-1997, SEC.1.
IC 27-8-14.7
Chapter 14.7. Coverage for Services Related to Prostate Cancer Screening

IC 27-8-14.7-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.170-1999 applies to accident and sickness insurance policies that are issued, delivered, or renewed after June 30, 1999.
As added by P.L.220-2011, SEC.446.

IC 27-8-14.7-1
"Accident and sickness insurance policy" defined
Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-14.7-2
"Insured" defined
Sec. 2. As used in this chapter, "insured" means a male individual who is entitled to coverage under a policy of accident and sickness
IC 27-8-14.7-3
"Prostate specific antigen test" defined
Sec. 3. As used in this chapter, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

IC 27-8-14.7-4
Coverage required
Sec. 4. (a) Except as provided in subsection (f), an insurer shall provide coverage for prostate specific antigen testing in any accident and sickness insurance policy that the insurer issues in Indiana.
(b) Except as provided in subsection (f), the coverage required under subsection (a) must include the following:
(1) At least one (1) prostate specific antigen test annually for an insured who is at least fifty (50) years of age.
(2) At least one (1) prostate specific antigen test annually for an insured who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.
(c) An insured may not be required to pay an annual deductible or coinsurance that is greater than an annual deductible or coinsurance established for similar benefits under the accident and sickness insurance policy. If the policy does not cover a similar benefit, the deductible or coinsurance may not be set at a level that materially diminishes the value of the prostate specific antigen testing benefit required by this chapter.
(d) Except as provided in subsection (f), the coverage that an insurer must provide under this chapter may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the accident and sickness insurance policy.
(e) Except as provided in subsection (f), the coverage that an insurer must provide is in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.
(f) In the case of insurance policies that are not employer based, the insurer must offer to provide the coverage described in subsections (a) through (e).
IC 27-8-14.8
Chapter 14.8. Coverage for Services Related to Colorectal Cancer Screening

IC 27-8-14.8-1
"Accident and sickness insurance policy" defined
Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:
(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and
(2) is issued on a group basis.
(b) "Accident and sickness insurance policy" 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-14.8-2
"Insured" defined
Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under an accident and sickness insurance policy.
As added by P.L.54-2000, SEC.2.

IC 27-8-14.8-3
Colorectal cancer testing coverage
Sec. 3. (a) Except as provided in subsection (d), an insurer shall provide coverage for colorectal cancer examinations and laboratory
tests for cancer for any nonsymptomatic insured, in accordance with the current American Cancer Society guidelines, in any accident and sickness insurance policy that the insurer issues in Indiana or issues for delivery in Indiana.

(b) For an insured who is:
   (1) at least fifty (50) years of age; or
   (2) less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society;
the coverage required under this section must meet the requirements set forth in subsection (c).

(c) An insured may not be required to pay an additional annual deductible or coinsurance for the colorectal cancer examination and laboratory testing benefit that is greater than an annual deductible or coinsurance established for similar benefits under an accident and sickness insurance policy. If the accident and sickness insurance policy does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer examination and laboratory testing benefit required under this section.

(d) In the case of an accident and sickness insurance policy that is not employer based, the insurer shall offer to provide the coverage described in this section.

As added by P.L.54-2000, SEC.2.
IC 27-8-15
Chapter 15. Small Employer Group Health Insurance

IC 27-8-15-0.1
Application of certain amendments to chapter
Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of sections 8.5, 10.5, 27, 28, 29, 30, 31, 32, 33, and 34 (before its repeal) of this chapter by P.L.93-1995 applies to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1995.

(2) The amendments made to sections 9, 14, and 19 of this chapter by P.L.93-1995 apply to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1995.

(3) Subject to section 31.1(a) of this chapter, as added by P.L.93-1995, section 16 of this chapter, as amended by P.L.93-1995, and section 31.1 of this chapter, as added by P.L.93-1995, apply to all small employer health insurance plans issued or renewed under this chapter, as amended by P.L.93-1995, after December 31, 1997.

(4) The addition of section 34.1 of this chapter by P.L.91-1998 applies to all small employer health insurance plans in force under this chapter on April 1, 1998.

(5) The amendments made to sections 10.5, 14, 19, 27, and 28 of this chapter by P.L.91-1998 apply to all small employer health insurance plans in force under this chapter on April 1, 1998.

As added by P.L.220-2011, SEC.447.

IC 27-8-15-1
Application of chapter
Sec. 1. This chapter applies to any group health insurance plan that is issued for delivery in Indiana to at least two (2) employees of a small employer located in Indiana if one (1) of the following conditions is met:

(1) Any part of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any part of the premium not including the administrative expenses of administering a payroll deduction plan where the employee contributes one hundred percent (100%) of the premium without reimbursement.

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of Section 106 or 162 of the United States Internal Revenue Code.

IC 27-8-15-2
Repealed
(Repealed by P.L.11-2011, SEC.46.)

IC 27-8-15-3
"Actuarial certification"
Sec. 3. As used in this chapter, "actuarial certification" means a written statement by a member of the American Academy of Actuaries that a small employer insurer is in compliance with section 16 of this chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the insurer in establishing premium rates for applicable health insurance plans.

IC 27-8-15-4
"Base premium rate"
Sec. 4. As used in this chapter, "base premium rate" means the lowest premium rate charged or that could have been charged under a rating system by the small employer insurer to small employers with similar case characteristics and benefit design characteristics.

IC 27-8-15-5
"Benefit design characteristics"
Sec. 5. As used in this chapter, "benefit design characteristics" means the following:
(1) Covered services.
(2) Cost sharing.
(3) Utilization management.
(4) Managed care networks.
(5) Any other features differentiating plan or benefit design.

IC 27-8-15-6
"Case characteristics"
Sec. 6. As used in this chapter, "case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer insurer, that are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics.

IC 27-8-15-7
"Commissioner"
Sec. 7. As used in this chapter, "commissioner" refers to the commissioner of the department of insurance.
IC 27-8-15-8
"Department"
Sec. 8. As used in this chapter, "department" refers to the department of insurance.
*As added by P.L.127-1992, SEC.1.*

IC 27-8-15-8.5
"Eligible employee"
Sec. 8.5. (a) As used in this chapter, "eligible employee" means an employee:
   (1) who is employed to work at least thirty (30) hours each week; and
   (2) who meets an applicable waiting period required by a small employer before gaining coverage under a health insurance policy.
(b) The term includes:
   (1) a sole proprietor;
   (2) a partner in a partnership; and
   (3) an owner of an S corporation;
regardless of whether the sole proprietor, partner, or owner is included as an employee for purposes of taxation of a small employer.
(c) The term does not include:
   (1) an employee who works on a temporary or substitute basis; or
   (2) a seasonal employee.

IC 27-8-15-9
"Health insurance plan"
Sec. 9. (a) Except as provided in section 28 of this chapter, as used in this chapter, "health insurance plan" or "plan" means any:
   (1) hospital or medical expense incurred policy or certificate;
   (2) hospital or medical service plan contract; or
   (3) health maintenance organization subscriber contract;
provided to the employees of a small employer.
(b) 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) Worker's compensation or similar insurance.
   (4) Automobile medical payment insurance.
   (5) A specified disease policy.
   (6) A short term insurance plan that:
       (A) may not be renewed; and
       (B) has a duration of not more than six (6) months.
   (7) 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.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(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.


**IC 27-8-15-10**

"**Insurer**"

Sec. 10. As used in this chapter, "insurer" means any person who provides health insurance in Indiana. The term includes the following:

(1) A licensed insurance company.
(2) A prepaid hospital or medical service plan.
(3) A health maintenance organization.
(4) A multiple employer welfare arrangement.
(5) Any person providing a plan of health insurance subject to state insurance law.


**IC 27-8-15-10.5**

"**Late enrollee**"

Sec. 10.5. (a) As used in this chapter, "late enrollee" means an eligible employee or a dependent of an eligible employee who did not request enrollment in a health insurance plan of a small employer during the initial enrollment period during which the individual was entitled to enroll under the health insurance plan.

(b) The term "late enrollee" does not include an eligible employee or the dependent of an eligible employee:

(1) who was covered under a health insurance plan or had health insurance coverage at the time coverage was previously offered to the employee or to the dependent of the employee;
(2) who stated in writing at the time coverage was offered that coverage under another health insurance plan was the reason for declining the enrollment, but only if the insurer required such a statement at the time and provided the employee with notice of the requirement (and the consequences of the requirement) at the time;
(3) whose coverage under this subsection:
(A) was under a COBRA continuation provision and the coverage under the provision was exhausted; or
(B) was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of
eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

(4) who requests enrollment under the terms of the plan not later than thirty (30) days after the date of exhaustion of coverage as described in subdivision (3)(A) or the termination of coverage or employer contributions as described in subdivision (3)(B).

(c) The term "late enrollee" does not include an eligible employee who is employed by a small employer that offers multiple health insurance plans and who elects a different plan during an open enrollment period.

(d) The term "late enrollee" does not include an eligible employee or the eligible employee's spouse or minor or dependent child where:

(1) a court has ordered that health insurance coverage be provided for the spouse or minor or dependent child of an eligible employee under the eligible employee's insurance plan; and

(2) the request for enrollment is made not more than thirty (30) days after the issuance of the court order.


IC 27-8-15-11
"Midpoint rate"
Sec. 11. As used in this chapter, "midpoint rate" means for small employers with similar case and benefit design characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

IC 27-8-15-12
"New business premium rate"
Sec. 12. As used in this chapter, "new business premium rate" means the premium rate charged or offered by the small employer insurer to small employers with similar case characteristics and benefit design characteristics for newly issued health insurance plans.

IC 27-8-15-13
"Rating period"
Sec. 13. As used in this chapter, "rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect, as determined by the small employer insurer.

IC 27-8-15-14
"Small employer"
Sec. 14. As used in this chapter, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

IC 27-8-15-15
"Small employer insurer"
Sec. 15. As used in this chapter, "small employer insurer" means any insurer that offers a health insurance plan covering the employees of a small employer.

IC 27-8-15-16
Premium rates
Sec. 16. Premium rates for a health insurance plan are subject to the following:
(1) For all small employer business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar benefit design characteristics, or the rates that could be charged to small employers under the rating system may not vary from the midpoint rate by more than thirty-five percent (35%) above or below the midpoint rate.
(2) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:
   (A) The percentage change in the new business premium rate for a plan with the same or similar benefit design characteristics measured from the first day of the prior rating period to the first day of the new rating period. For a plan for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.
   (B) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.
   (C) Any adjustment due to change in benefit design characteristics or change in the case characteristics of the small employer.
(3) For health insurance plans issued before July 1, 1992, a
premium rate for a rating period may exceed the ranges described in subdivisions (1) and (2) for five (5) years following July 1, 1992. The percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. For a plan for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

(B) Any adjustment due to change in benefit design characteristics or change in the case characteristics of the small employer.


IC 27-8-15-17
Rating factors
Sec. 17. (a) This chapter is not intended to affect the use by a small employer insurer of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates.

(b) A small employer insurer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a plan with substantially the same benefit design characteristics.


IC 27-8-15-18
Offer to transfer
Sec. 18. A small employer insurer may not offer to transfer a small employer into or out of a plan with substantially the same benefit design unless the offer is made to transfer all small employers in that plan without regard to case characteristics, claim experience, health status, or duration since issue.


IC 27-8-15-19
Cancellation or refusal of renewal of plans
Sec. 19. Except as provided in section 20 of this chapter, a small employer insurer may only cancel or refuse to renew a health insurance plan for the following reasons:

(1) Nonpayment of required premiums.

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.

(3) The small employer has failed to comply with a material plan provision relating to employer contribution or group participation rules.

(4) In the case of a small employer insurer that offers coverage
in a market through a network plan, there is no longer any insured individual in connection with the plan who lives, resides, or works:
   (A) in the service area of the small employer insurer; or
   (B) in the area for which the issuer is authorized to do business.
(5) In the case of coverage that is made available through one (1) or more bona fide associations, the membership of the small employer in the association ceases, but only if the coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to an insured individual.
(6) In a case in which an insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small employer market, that coverage may be discontinued by the insurer only if:
   (A) the insurer provides notice of the insurer's intent to discontinue the coverage to each small employer provided with the coverage;
   (B) the insurer offers the option to purchase all other health insurance coverage currently being offered by the insurer to the small employer to each small employer that is provided with the coverage; and
   (C) in exercising the option to discontinue the coverage in offering the option of coverage under clause (B), the insurer acts uniformly without regard to:
      (i) the claims experience of the small employer groups; or
      (ii) any health status related factor relating to any eligible employee or dependent of an eligible employee who is covered or who may become eligible for the coverage.

IC 27-8-15-20
Renewal cessation; notice
   Sec. 20. (a) A small employer insurer may cease to renew all small employer plans.
   (b) The insurer shall provide notice to all affected health insurance plans and to the commissioner at least one (1) year before termination of coverage unless the coverage is placed with another insurer.

IC 27-8-15-21
Renewal cessation; prohibitions
   Sec. 21. (a) An insurer who ceases to renew all small employer plans may not do the following:
      (1) Accept any new small employer business for five (5) years after the notice of nonrenewal of the plans.
      (2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to all affected
employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

(b) The commissioner may suspend the penalty under subsection (a)(1) upon a finding by the commissioner that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.


IC 27-8-15-22
Disclosure of premium rate changes

Sec. 22. Each small employer insurer shall make reasonable disclosure in solicitation and sales materials provided to small employers of the provisions affecting premium rate changes.


IC 27-8-15-23
Maintenance of rating and renewal practice information and documentation

Sec. 23. Each small employer insurer shall maintain for three (3) years at the insurer's principal place of business a complete and detailed description of the insurer's rating practices and renewal underwriting practices, including information and documentation that demonstrate that the insurer's rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.


IC 27-8-15-24
Maintenance of actuarial certification; submission to department

Sec. 24. (a) Each small employer insurer shall maintain an actuarial certification verifying that the insurer is in compliance with this chapter and that the rating methods of the insurer are actuarially sound. A copy of the certification shall be retained by the insurer at the insurer's principal place of business for three (3) years.

(b) Before March 1 of each year, each small employer insurer shall submit to the department a copy of the actuarial certification maintained under subsection (a).


IC 27-8-15-25
Availability of information and documentation to commissioner; disclosure by commissioner

Sec. 25. A small employer insurer shall make the information and documentation described in section 23 of this chapter available to the commissioner upon request. The information is proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside of the department except as agreed to by the insurer or as ordered by a court with jurisdiction.

IC 27-8-15-26
Suspension of premium rate provisions
Sec. 26. The commissioner may suspend all or any part of section 16 of this chapter as to the premium rates applicable to one (1) small employer for at least one (1) rating period upon a filing by the small employer insurer and a finding by the commissioner that either:
(1) the suspension is reasonable in light of the financial condition of the insurer; or
(2) the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

IC 27-8-15-27
Application in conformity with act; compliance
Sec. 27. (a) This section 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.
(b) A health insurance plan provided by a small employer insurer to a small employer must comply with the following:
(1) The benefits provided by a plan to an eligible employee enrolled in the plan may not be excluded, limited, or denied for more than nine (9) months after the effective date of the coverage because of a preexisting condition of the eligible employee, the eligible employee's spouse, or the eligible employee's dependent.
(2) The plan may not define a preexisting condition, rider, or endorsement more restrictively than as a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the effective date of enrollment in the plan.

IC 27-8-15-28
Waiver of exclusion and limitation period
Sec. 28. (a) As used in this section, "health insurance plan" means coverage provided under any of the following:
(1) A hospital or medical expense incurred policy or certificate.
(2) A hospital or medical service plan contract.
(3) A health maintenance organization subscriber contract.
(4) Medicare or Medicaid.
(5) An employer based health insurance arrangement.
(6) An individual health insurance policy.
(7) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.
(8) An employee welfare benefit plan (as defined in 29 U.S.C.
(9) A conversion policy issued under section 31 or 31.1 of this chapter.

(b) Except as provided in section 29 of this chapter, a small employer insurer shall waive the exclusion period described in section 27 of this chapter applicable to a preexisting condition or the limitation period with respect to a particular service in a health insurance plan for the time an eligible employee or a dependent of an eligible employee was previously covered by a health insurance plan if the following conditions are met:

(1) The eligible employee or a dependent of the eligible employee was previously covered by a health insurance plan that provided benefits with respect to the particular service.

(2) Coverage under the health insurance plan was continuous to a date not more than sixty-three (63) days before the effective date of enrollment by:

(A) the eligible employee; or

(B) a dependent of the eligible employee.

(c) In determining whether an eligible employee or a dependent of the eligible employee meets the requirements of subsection (b)(2), a waiting period imposed by a small employer insurer or small employer before new coverage may become effective must be excluded from the calculation.

(d) This section does not preclude the application of any waiting period applicable to all new enrollees under a plan.


IC 27-8-15-29
Application in conformity with act: exclusion of coverage

Sec. 29. (a) This section 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.

(b) A plan may exclude coverage for a late enrollee or the late enrollee's covered spouse or dependent for not more than fifteen (15) months.

(c) If a late enrollee or the late enrollee's covered spouse or dependent has a preexisting condition, a plan may exclude coverage for the preexisting condition for not more than fifteen (15) months.

(d) If a period of exclusion from coverage under subsection (b) and a preexisting condition exclusion under subsection (c) are applicable to the late enrollee, the combined period of exclusion may not exceed fifteen (15) months from the date that the eligible employee enrolls for coverage under the health insurance plan.


IC 27-8-15-30
Plan modifications prohibited

Sec. 30. Except as permitted under sections 27 and 29 of this chapter, a small employer insurer shall not modify a health insurance plan with respect to:

(1) a small employer; or
(2) an eligible employee or dependent;
through riders, endorsements, or otherwise to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

As added by P.L.93-1995, SEC.18.

IC 27-8-15-31
Conversion policy

Sec. 31. (a) If an eligible employee who has been continuously covered under a health insurance plan for at least ninety (90) days:

(1) loses coverage under the plan as the result of:
   (A) termination of employment;
   (B) reduction of hours;
   (C) marriage dissolution; or
   (D) attainment of any age specified in the plan;
(2) is not eligible for continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985; and (3) requests a conversion policy from the small employer insurer that insured the health insurance plan;
the individual is entitled to receive a conversion policy from the small employer insurer.

(b) A request under subsection (a) must be made within thirty (30) days after the individual loses coverage under the health insurance plan.

(c) The premium for a conversion policy issued under this section shall not exceed one hundred fifty percent (150%) of the rate that would have been charged under the small employer health insurance plan with respect to the individual if the individual had been covered as an eligible employee under the plan during the same period. If the health insurance plan under which the individual was covered is canceled or is not renewed, the rates shall be based on the rate that would have been charged with respect to the individual if the plan had continued in force, as determined by the small employer insurer in accordance with standard actuarial principles.

(d) A conversion policy issued under this section must be approved by the insurance commissioner as described in IC 27-8-5-1. The commissioner may not approve a conversion policy unless the policy and its benefits are:

(1) comparable to those required under IC 27-13-1-4(a)(2) through IC 27-13-1-4(a)(5);
(2) reasonable in relation to the premium charged; and
(3) in compliance with IC 27-8-6-1.

If the benefit limits of the conversion policy are not more than the benefit limits of the small employer's health insurance plan, the small employer insurer shall credit the individual with any waiting period,
deductible, or coinsurance credited to the individual under the small employer's health insurance plan.

(e) This section expires on the effective date of a mechanism enacted by the general assembly to offset the potential fiscal impact on small employers and small employer insurers that results from the establishment of a continuation policy under section 31.1 of this chapter.


IC 27-8-15-31.1
Continuing coverage

Sec. 31.1. (a) This section becomes effective on the effective date of a mechanism enacted by the general assembly to offset the potential fiscal impact on small employers and small employer insurers that results from the establishment of a continuation policy under this section. This section does not apply to an individual who is eligible for coverage under a group health plan (as defined in 29 U.S.C. 1167).

(b) If an eligible employee who has been employed by the same small employer for at least one (1) year and continuously covered under a health insurance plan for at least ninety (90) days, or a dependent of such eligible employee:

(1) loses coverage under the plan as the result of:
   (A) termination of the eligible employee's employment;
   (B) reduction of the eligible employee's hours;
   (C) dissolution of marriage; or
   (D) attainment of any age specified in the plan; and

(2) requests continuing coverage from the small employer insurer that insured the health insurance plan;

the individual and any dependents of the individual are entitled to receive continuing coverage from the small employer insurer.

(c) A small employer shall notify an individual of the individual's possible right to continuing coverage under subsection (b) by presenting notice to the individual in writing within ten (10) days after the individual becomes an eligible employee. The notice must be presented directly to the eligible employee and must include:

(1) the conditions under which the eligible employee may qualify for continuing coverage;
(2) the name, address, and telephone number of the small employer insurer providing insurance to the small employer; and

(3) a statement that emphasizes the eligible employee's responsibility to contact the small employer insurer that insures the small employer at the time the eligible employee qualifies for continuing coverage under this section within thirty (30) days after becoming eligible for continuing coverage.

(d) An individual who wishes to receive continuing coverage must request continuing coverage from the small employer insurer in writing within thirty (30) days after losing coverage under subsection
(b)(1).

(e) An individual electing continuing coverage must pay to the employer, in advance of the date the employer is required to make payments for insurance, but not more than one (1) time each month, the total premium amount required for continuing coverage.

(f) An individual who fails to:

1) provide notice to a small employer insurer under subsection (d); or
2) timely pay the premium as described in subsection (e);
relieves the employer and the small employer insurer of any responsibility to the individual for continuing coverage.

(g) A notification of the continuation privilege must accompany or be included in each certificate of coverage.

(h) Continuing coverage shall not be available to an individual who was discharged because the individual committed a felony or theft in connection with the individual's work, provided that:

1) the individual admits participating in the felony or theft;
2) the discharge is upheld through binding arbitration; or
3) the act resulted in a conviction or an order of or supervision by a court.

(i) The premium for continuing coverage referred to in subsection (b) for any given period shall not exceed one hundred two percent (102%) of the rate that would have been charged under the health insurance plan with respect to the individual if the individual had been covered as an eligible employee under the plan during the same period. If the health insurance plan under which the individual was covered is canceled or is not renewed, the individual may apply for a conversion policy under this section.

(j) Benefits provided under the continuing coverage referred to in subsection (b) may not be less than the benefits provided under the health insurance plan. If the plan limits of the continuing coverage are not greater than the plan limits of the health insurance plan, the small employer insurer shall credit the insured with any waiting period, deductible, and coinsurance to the extent that the waiting period, deductible, or coinsurance was credited to the individual under the health insurance plan.

(k) Continuing coverage provided under this section may not last longer than twelve (12) months. If a small employer changes the health insurance plan during the time that continuing coverage is provided to an individual under this section, the small employer shall notify the individual in writing within thirty (30) days of the change, and the individual is entitled to apply for a conversion policy under this section within thirty (30) days of receiving the notice.

(l) A small employer insurer who provides continuing coverage under this section may not refuse to accept for coverage under a conversion policy any individual who remained continuously covered under this section if the individual can prove that:

1) the individual is entitled to and has exhausted the benefits available under continuing coverage or the health insurance plan under which the individual was covered is canceled or is not
renewed under the provisions of section 19 of this chapter;
(2) the continuing coverage was continuous to a date not more
than thirty (30) days before the effective date of the coverage
the individual is applying for under this subsection; and
(3) the individual is not eligible for coverage under any other
employer health insurance plan.

The premium for a conversion policy issued under this subsection
shall not exceed one hundred thirty-five percent (135%) of the rate
that would have been charged under the health insurance plan with
respect to the individual if the individual had been covered as an
eligible employee under the plan during the same period. If the health
insurance plan under which the individual was covered is canceled or
is not renewed, the rate shall be based on the rate that would have
been charged with respect to the individual if the plan had continued
in force, as determined by the small employer insurer in accordance
with standard actuarial principles.


IC 27-8-15-32
Employees becoming eligible after employer's commencement of
health insurance plan entitled to coverage

Sec. 32. (a) If an individual:
(1) becomes an eligible employee of a small employer after the
date that a small employer insurer first insures an eligible
employee of the small employer under a health insurance plan;
and
(2) is not a late enrollee;
the individual and all dependents of the individual are entitled to
coverage under section 33 of this chapter, subject to the provisions of
sections 27 and 28 of this chapter.


IC 27-8-15-33
Mandatory coverage by employer insurer to all employer's eligible
employees and employees' dependents; employees declining
coverage; minimum participation and contribution requirements

Sec. 33. (a) If a small employer insurer offers coverage under a
health insurance plan to a small employer, the small employer insurer
shall provide the employer coverage under the plan for:
(1) all eligible employees of the small employer; and
(2) the dependents of all eligible employees of the small
employer.

(b) Except as provided in section 29 of this chapter with respect
to late enrollees, a small employer insurer shall not limit the insurer's
provision of coverage to:
(1) certain individuals in a small employer group; or
(2) a part of a small employer group.

(c) This section does not prohibit an eligible employee from
declining coverage under this section.

(d) Nothing in this chapter prohibits a small employer insurer from
including minimum participation and contribution requirements in its offer of coverage.

As added by P.L.93-1995, SEC.22.

IC 27-8-15-34
Repealed
(Repealed by P.L.91-1998, SEC.24.)

IC 27-8-15-34.1
All products required to be offered; all employers required to be accepted

Sec. 34.1. Except as provided in 29 U.S.C. 1191a and 42 U.S.C. 300gg, a small employer insurer must:

(1) offer to any small employer all products that are approved for sale in the small group market and that the insurer is actively marketing; and

(2) accept any employer that applies for any of those products.

IC 27-8-15.5
Chapter 15.5. Small Employer Insurer Voluntary Reinsurance Program

IC 27-8-15.5-1
Applicability of definitions
Sec. 1. The definitions set forth in IC 27-8-15 apply throughout this chapter.

IC 27-8-15.5-2
"Board" defined
Sec. 2. As used in this chapter, "board" refers to the Indiana small employer health reinsurance board established by section 5 of this chapter.

IC 27-8-15.5-3
"Program" defined
Sec. 3. As used in this chapter, "program" refers to the program of reinsurance established by section 6 of this chapter.

IC 27-8-15.5-4
"Reinsuring carrier" defined
Sec. 4. As used in this chapter, "reinsuring carrier" means a small employer insurer that obtains reinsurance under this chapter.

IC 27-8-15.5-5
Establishment of board
Sec. 5. The Indiana small employer health reinsurance board is established. The board shall supervise and control the program of reinsurance established under this chapter.

IC 27-8-15.5-6
Establishment of program
Sec. 6. The Indiana small employer health reinsurance program is established. Any small employer insurer that is doing or planning to do business in Indiana may become a member of the program as described in section 12 of this chapter.

IC 27-8-15.5-7
Members of board
Sec. 7. (a) The board consists of the commissioner or the commissioner's designated representative, who serves as an ex officio member of the board, and ten (10) members. The members of the board shall be appointed by the commissioner, who shall name a
chairman of the board one (1) time every three (3) years.

(b) The members of the board appointed under subsection (a) must include the following:
   (1) One (1) representative of health maintenance organizations.
   (2) One (1) representative of providers (as defined in IC 27-13-1-28).
   (3) Six (6) representatives of small employer insurers.
   (4) Two (2) representatives of small employers.

(c) A member of the board is appointed for a term of three (3) years.

(d) The term of a board member appointed under subsection (a) continues until the board member's successor is appointed.

(e) The commissioner shall fill a vacancy in an appointive member's position on the board.

(f) A board member may be removed by the commissioner for cause.

(g) At least six (6) members of the board must be present for the board to conduct official business. The affirmative vote of at least six (6) members of the board is necessary for the board to take official action.

(h) The board shall meet at least one (1) time each calendar quarter at the call of the commissioner.


IC 27-8-15.5-8
Plan of operation; submission; approval; amendments
Sec. 8. (a) Not later than two hundred seventy (270) days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation.

(b) The commissioner may adopt the plan of operation as a rule under IC 4-22-2 if the commissioner determines the plan will:
   (1) ensure the fair, reasonable, and equitable administration of the program; and
   (2) provide for the sharing of program gains or losses on an equitable and a proportionate basis in accordance with this chapter.

(c) After the adoption of a plan of operation under this section, the board may submit to the commissioner any proposed amendments to the plan the board considers necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may adopt under IC 4-22-2 proposed amendments submitted under this subsection as amendments to the rule adopted under subsection (b).


IC 27-8-15.5-9
Plan of operation; temporary plan
Sec. 9. (a) If the board fails to submit a suitable plan of operation within the time allowed under section 8 of this chapter, the commissioner shall adopt rules under IC 4-22-2 establishing a
temporary plan of operation.

(b) The commissioner shall amend or rescind under IC 4-22-2 any temporary plan of operation adopted under this section when a plan of operation is submitted by the board and approved by the commissioner.


IC 27-8-15.5-10
Plan of operation; requirements

Sec. 10. The plan of operation submitted and adopted under section 8 of this chapter must do the following:

1. Establish procedures for the handling and accounting of program assets and money.
2. Provide for an annual fiscal report to the commissioner.
3. Establish procedures for selecting an insurer to administer the program.
4. Establish the powers and duties of the administering insurer, including:
   (A) notifying all members regarding annual assessments; and
   (B) collecting of assessments.
5. Establish procedures for reinsuring risks under this chapter.
6. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses that are incurred or estimated to be incurred by the program.
7. Establish a methodology for applying the dollar thresholds contained in this chapter in the case of small employer insurers that pay or reimburse health care providers through capitation or salary.
8. Provide for any additional matters necessary for the implementation and administration of the program.


IC 27-8-15.5-11
Powers of board

Sec. 11. (a) The board, in supervising and controlling the program, has the general powers and authority granted under IC 27 to insurance companies and health maintenance organizations authorized to transact business in Indiana, except the power to issue health insurance plans directly to groups or individuals.

(b) In addition to exercising the powers conferred by subsection (a), the board may do the following:

1. Enter into contracts that are necessary or proper to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:
   (A) similar programs of other states for the joint performance of common functions; or
   (B) persons or other organizations for the performance of administrative functions.
2. Sue or be sued, including taking any legal action necessary or proper to recover assessments and penalties for, on behalf of,
or against the program or any reinsuring insurer.

(3) Take any legal action necessary to avoid the payment of improper claims against the program.

(4) Define the health insurance plans for which reinsurance is provided.

(5) Issue reinsurance policies under this chapter.

(6) Establish rules, conditions, and procedures for reinsuring risks under the program.

(7) Establish actuarial functions as appropriate for the operation of the program.

(8) Impose assessments on reinsuring carriers under this chapter, and make advance interim assessments that are reasonable and necessary for organizational and interim operating expenses.

(9) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy, and other contract design, and any other function within the authority of the program.

(c) Any interim assessments imposed under subsection (b)(8) shall be credited as offsets against any regular assessments due from reinsuring carriers after the close of the fiscal year.

(d) Any notes or other evidence of indebtedness of the program that are not in default:

(1) are legal investments for small employer insurers; and

(2) may be carried by small employer insurers as admitted assets.


IC 27-8-15.5-12
Election to become member of program

Sec. 12. (a) A small employer insurer may elect to become a member of the program by filing a written intention to participate with the commissioner not later than sixty (60) days after the:

(1) board submits a plan of operation to the commissioner and the commissioner adopts the plan under section 8 of this chapter; or

(2) commissioner establishes a temporary plan of operation for the program under section 9 of this chapter; whichever occurs first.

(b) A small employer insurer that fails to become a member of the program under subsection (a) may only become a member by filing a written intention with the commissioner to participate in the program:

(1) three (3) years; or

(2) at the end of any three (3) year interval; after the program begins under subsection (a)(1) or (a)(2).

(c) Notwithstanding subsections (a) and (b), the commissioner may permit a small employer insurer to become a member of the program at other times for reasons based on financial solvency.

IC 27-8-15.5-13
Maximum level of coverage; other limits on coverage
Sec. 13. (a) The board may establish a maximum level of coverage up to which the program will reinsure a health insurance plan and beyond which the program will not reinsure a health insurance plan.
(b) A member of the program must allow any employer insured by the member to maintain the same health insurance plan and may reinsure only that part of the health insurance plan that is consistent with the program established by the board.

IC 27-8-15.5-14
Time requirements for reinsurance
Sec. 14. (a) A small employer insurer may reinsure an entire small employer group not later than sixty (60) days after the commencement of the coverage of the small employer group under a health insurance plan.
(b) A small employer insurer may reinsure coverage of an eligible employee or the dependent of an eligible employee under a health insurance plan issued to a small employer not later than sixty (60) days after the coverage of the eligible employee or dependent of the eligible employee commences.

IC 27-8-15.5-15
Reimbursement of reinsuring carriers
Sec. 15. The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the reinsuring carrier has incurred an initial level of claims for the employee or dependent of five thousand dollars ($5,000) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year, and the program shall reinsure the remainder. The liability of a reinsuring carrier under this section may not exceed ten thousand dollars ($10,000) in any calendar year with respect to any reinsured individual.

IC 27-8-15.5-16
Adjustments in initial level of claims and maximum limit to be retained
Sec. 16. The board may annually adjust the initial level of claims and the maximum limit to be retained by a reinsuring carrier to reflect increases in costs and utilization within the standard market for health insurance plans in Indiana. The adjustment may not be lower than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes and the commissioner approves a lower adjustment factor.
IC 27-8-15.5-17
Termination of reinsurance
Sec. 17. A small employer insurer that issues a health insurance plan to a small employer and obtains reinsurance for the health insurance plan under this chapter may terminate the reinsurance for one (1) or more of the reinsured employees or dependents of the small employer:
(1) on any anniversary of the health insurance plan; or
(2) when the reinsured employee leaves the employment of the small employer.

IC 27-8-15.5-18
Reduction of premium rates for reinsurance of federally qualified HMOs
Sec. 18. Premium rates charged under this chapter for reinsurance to a health maintenance organization that is federally qualified under 42 U.S.C. 300e et seq., and as such is subject to limits on the amount of risk that may be ceded to the program that are more restrictive than those set forth in section 15 of this chapter, must be reduced to reflect the part of the risk, if any, that may not be ceded to the program due to the more restrictive limits.

IC 27-8-15.5-19
Managed care and claims handling techniques
Sec. 19. A reinsuring carrier shall apply all managed care and claims handling techniques, including:
(1) utilization review;
(2) individual case management;
(3) preferred provider provisions; and
(4) other managed care provisions or methods of operation; consistently with respect to reinsured and nonreinsured business.

IC 27-8-15.5-20
Methodology for determining premium rates
Sec. 20. (a) The board, as part of the plan of operation adopted under section 8 of this chapter, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals under this chapter.
(b) The methodology established under this section must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer insurers in Indiana.
(c) The methodology established under this section must provide for the development of base reinsurance premium rates. The base reinsurance premium rates are multiplied by the factors set forth in
section 21 of this chapter to determine the premium rates for the program.

(d) The base reinsurance premium rates referred to in subsection (c) shall be established by the board, subject to the approval of the commissioner.


IC 27-8-15.5-21
Multiplication factors for premium rates

Sec. 21. (a) Premiums charged by the program for reinsurance are as follows:

(1) An entire small employer group may be reinsured for a rate that is one hundred fifty percent (150%) of the base reinsurance premium rate for the group that is developed under section 20(c) of this chapter.

(2) An eligible employee or the dependent of an eligible employee may be reinsured for a rate that is five hundred percent (500%) of the base reinsurance premium rate for the individual established under this section.

(b) The board shall periodically review the methodology established under section 20 of this chapter, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes in the methodology. The changes proposed by the board take effect upon approval by the commissioner.

(c) The board may consider adjustments to the premium rates charged for reinsurance under the program to reflect the use of effective cost containment and managed care arrangements.


IC 27-8-15.5-22
Premium rates for health insurance plans to comply with IC 27-8-15

Sec. 22. If a health insurance plan issued to a small employer is entirely or partially reinsured under the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in IC 27-8-15.


IC 27-8-15.5-23
Determination and report of net loss

Sec. 23. (a) Before March 1 of each year, the board shall determine and report to the commissioner the program's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

IC 27-8-15.5-24

**Determination of assessments against reinsuring carriers**

Sec. 24. (a) The board, as part of the plan of operation adopted under section 8 of this chapter, shall establish a formula by which to impose assessments against reinsuring carriers.

(b) The assessment formula established under subsection (a) must result in assessments apportioned by the board among all small employer insurers participating in the program in proportion to:

1. the small employer insurers' respective shares of the total premiums;
2. the net of reinsurance premiums paid for coverage under the program earned from health insurance plans covering small employers that are issued by participating small employer insurers during the calendar year coinciding with or ending during the fiscal year of the program; or
3. any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation.

(c) Health insurance plan premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(d) An assessment determined under this section may not exceed one percent (1%) of total net premiums annually. If an excess is actuarially projected, the commissioner may take any action necessary to lower the assessment to the maximum level of one percent (1%) of total net premiums.

(e) The board, with the approval of the commissioner, may change the assessment formula established under this section from time to time as appropriate.

(f) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations and federally qualified under 42 U.S.C. 300e et seq., to the extent that restrictions are placed on them that are not imposed on other small employer insurers.

*As added by P.L.193-1996, SEC.1.*

IC 27-8-15.5-25

**Estimates of assessments needed to fund losses**

Sec. 25. (a) Before March 1 of each year the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed two percent (2%) of total premiums earned in the previous calendar year from health insurance plans delivered or issued for delivery to small employers by reinsuring carriers, the board shall evaluate the operation of the program and report the board's findings, including any recommendations for changes in the plan of operation.
adopted under section 8 of this chapter, to the commissioner not more than ninety (90) days after the end of the calendar year in which the losses were incurred. The evaluation must:

(1) include an estimate of future assessments; and
(2) consider the:
   (A) administrative costs of the program;
   (B) appropriateness of the premiums charged;
   (C) level of insurer retention under the program; and
   (D) costs of coverage for small employers.

(c) If the board fails to file a report with the commissioner under subsection (b) not later than ninety (90) days after the end of the calendar year, the commissioner may:

(1) evaluate the operation of the program; and
(2) implement the amendments to the plan of operation adopted under section 8 of this chapter that the commissioner considers necessary to reduce future losses and assessments.


IC 27-8-15.5-26
Use of excess assessments

Sec. 26. If assessments paid by reinsuring carriers under this chapter exceed the net losses of the program, the excess is held at interest and used by the board to:

(1) offset future losses, including reserves for incurred but not reported claims; or
(2) reduce program premiums.


IC 27-8-15.5-27
Determination of reinsuring carrier's proportion of assessments

Sec. 27. (a) The board shall annually determine each reinsuring carrier's proportion of the assessment for reinsurance under this chapter based on annual statements and other reports considered necessary by the board and filed with the board by the reinsuring carriers.

(b) The plan of operation adopted under section 8 of this chapter must provide for the imposition of an interest penalty on reinsuring carriers for late payment of assessments.


IC 27-8-15.5-28
Deferments from assessments

Sec. 28. (a) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition.

(b) If all or part of an assessment against a reinsuring carrier is deferred under subsection (a), the amount deferred is assessed against
the other reinsuring carriers in a manner consistent with the basis for assessment under this chapter.

(c) A reinsuring carrier that receives a deferment under this section:

(1) remains liable to the program for the amount deferred; and

(2) may not reinsure an individual or a group with the program until the reinsuring carrier pays the assessment.


IC 27-8-15.5-29
Participation not to be basis for legal action, liability, or penalty

Sec. 29. The participation of small employer insurers in the program as reinsuring carriers, the establishment of rates, forms, or procedures under this chapter, or any other joint or collective action required by this chapter may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of the program's reinsuring carriers, either jointly or separately.


IC 27-8-15.5-30
Tax exemption

Sec. 30. The program is exempt from all taxes imposed by the state.

IC 27-8-16
Chapter 16. Medical Claims Review

IC 27-8-16-0.5
Applicability of chapter
Sec. 0.5. (a) This chapter applies to the following:
   (1) A person who conducts medical claims review concerning
       health care services delivered to an enrollee in Indiana.
   (2) A person who acts as a claim review consultant concerning
       the:
           (A) appropriateness of; or
           (B) amount charged for;
       a health care service delivered to an enrollee in Indiana.
(b) This chapter does not apply to:
   (1) the payment of benefits or compensation;
   (2) the furnishing of medical, surgical, hospital, or nursing
       services; or
   (3) the payment by an insurer or employer to the provider of
       health care services for services provided;
under IC 22.

IC 27-8-16-1
"Claim review agent" defined
Sec. 1. (a) As used in this chapter, "claim review agent" means
any entity performing medical claims review on behalf of an
insurance company, a health maintenance organization, or another
benefit program providing payment, reimbursement, or
indemnification for health care costs to an enrollee.
(b) The term does not include the following:
   (1) An insurance company authorized under IC 27-1-3 or
       IC 27-1-17 to do business in Indiana or the company's affiliated
       companies.
   (2) An entity acting on behalf of the federal or state government.
       However, an agent described in this subdivision who performs
       medical claims review for a person other than the federal or
       state government is a claim review agent who is subject to the
       requirements of this chapter.
   (3) A health maintenance organization or limited service health
       maintenance organization that holds a certificate of authority to
       operate under IC 27-13.
   (4) An insurance administrator that is licensed under
       IC 27-1-25.
   (5) An individual qualified and acting as an expert witness
       under the Indiana Rules of Trial Procedure.

IC 27-8-16-1.5
"Claim review consultant" defined
Sec. 1.5. (a) As used in this chapter, "claim review consultant" means a person who:

(1) makes a recommendation or provides consultation to:
   (A) an entity engaged in performing medical claims review; or
   (B) an insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs to an enrollee;

   concerning the appropriateness of a health care service or the amount charged for a health care service delivered to an enrollee in Indiana; and

(2) is not an employee of an entity referred to in subdivision (1)(A) or (1)(B).

(b) Making a recommendation or providing consultation concerning a health care service does not render a person a claim review consultant under this section if the recommendation or consultation concerns:

(1) coverage provided; or

(2) medical services rendered;

under IC 22.

(c) The term "claim review consultant" does not include the following:

(1) An insurance company authorized under IC 27 to do business in Indiana.

(2) An entity acting on behalf of the federal or state government. However, an agent described in this subdivision who performs medical claims review for a person other than the federal or state government is a claim review agent who is subject to the requirements of this chapter.

(3) A health maintenance organization or limited service health maintenance organization that holds a certificate of authority to operate under IC 27-13.

(4) An insurance administrator that is licensed under IC 27-1-25.

(5) An individual qualified and acting as an expert witness under the Indiana Rules of Trial Procedure.

(6) A person who engages in the prospective, concurrent, or retrospective utilization review of health care services.

(7) A person who engages in the identification of alternative, optional medical care that:
   (A) requires the approval of the enrollee or covered individual; and
   (B) does not affect coverage or benefits if rejected by the enrollee or covered individual.

(8) An individual who is a licensed health care provider who makes a recommendation or provides consultation concerning the appropriateness of health care service. However, this exception does not apply if the individual:
   (A) makes any recommendations or provides consultation
concerning the amount charged for a health care service delivered in Indiana;
(B) makes any recommendations or provides consultation concerning the appropriateness of hospital services provided by a hospital licensed under IC 12-25 or IC 16-21;
(C) is employed by or under contract with an entity that is required to be registered under this chapter; or
(D) has received more than five thousand dollars ($5,000) in compensation during the present calendar year for providing consultation services concerning the appropriateness of health care services delivered to enrollees in Indiana.

(9) A claim review agent under section 1 of this chapter.


IC 27-8-16-2
"Department" defined
Sec. 2. As used in this chapter, "department" refers to the department of insurance.

IC 27-8-16-3
"Enrollee" defined
Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for the costs of health care for:
   (1) the individual;
   (2) eligible dependents of the individual; or
   (3) both the individual and the individual's eligible dependents.

IC 27-8-16-4
"Medical claims review" defined
Sec. 4. (a) As used in this chapter, "medical claims review" means the determination of the reimbursement to be provided under the terms of an insurance policy, a health maintenance organization contract, or another benefit program providing payment, reimbursement, or indemnification for health care costs based on the appropriateness of health care services or the amount charged for a health care service delivered to an enrollee.
   (b) The term does not include the prospective, concurrent, or retrospective utilization review of health care services.
   (c) The term does not include the identification of alternative, optional medical care that:
      (1) requires the approval of the enrollee or covered individual; and
      (2) does not affect coverage or benefits if rejected by the enrollee or covered individual.
IC 27-8-16-4.5
"Person" defined
Sec. 4.5. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or an unincorporated association.

IC 27-8-16-5
Certificate of registration; issuance to agent
Sec. 5. (a) A claim review agent may not conduct medical claims review concerning health care services delivered to an enrollee in Indiana unless the claim review agent holds a certificate of registration issued by the department under this chapter.
(b) To obtain a certificate of registration under this chapter, a claim review agent must submit to the department an application containing the following:
   (1) The name, address, telephone number, and normal business hours of the claim review agent.
   (2) The name and telephone number of a person that the department may contact concerning the information in the application.
   (3) Documentation necessary for the department to determine that the claim review agent is capable of satisfying the minimum requirements set forth in section 7 of this chapter.
(c) An application submitted under this section must be:
   (1) signed and verified by the applicant; and
   (2) accompanied by an application fee in the amount established under subsection (d).
The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.
(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.
(e) The department shall issue a certificate of registration to a claim review agent that satisfies the requirements of this section.

IC 27-8-16-5.2
Certificate of registration; application; requirements; application fee
Sec. 5.2. (a) A person may not act as a claim review consultant concerning health care services delivered to an enrollee in Indiana
unless the person holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a person must submit to the department an application containing the following:

1. The name, address, telephone number, and normal business hours of the person.
2. The name and telephone number of a person that the department may contact concerning the information in the application.
3. Documentation necessary for the department to determine that the person is capable of satisfying the minimum requirements set forth in this chapter.

(c) An application submitted under this section must be:

1. Signed and verified by the applicant; and
2. Accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review consultant that satisfies the requirements of this section.


IC 27-8-16-6 Certificate of registration; renewal; transfer; notice of change in information

Sec. 6. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed on June 30 of each year. To obtain the renewal of a certificate of registration, a claim review agent or a claim review consultant must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 5(d) of this chapter. The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the person to which the certificate of registration is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the claim review agent or claim review consultant that submitted the application shall notify
the department of the change in writing not more than thirty (30) days after the change.

IC 27-8-16-7
Minimum claim review agent requirements
Sec. 7. A claim review agent must satisfy the following minimum requirements:
(1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.
(2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.
(3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.
(4) Protect the confidentiality of the medical records disclosed to the claim review agent.
(5) Include in every notification of a medical review determination based on the appropriateness of health care services delivered to an enrollee the principal reason for the determination.
(6) Ensure that every medical claims review determination based on the appropriateness of health care services delivered to an enrollee is:
   (A) made by a provider; or
   (B) determined in accordance with standards or guidelines approved by a provider;
who holds a license in the same discipline as the provider who rendered the service.
(7) Include in every notification of a medical review determination based on the appropriateness of the amount charged for a health care service delivered to an enrollee the following:
   (A) An explanation of the factual basis for the determination.
   (B) If the determination is based on any information from a claims data base, the name and address of the person or entity compiling the data base.
   (C) If the determination is based on any information from a claims data base, a statement whether any of the information was obtained from a data base regarding amounts charged for health services performed outside Indiana.
   (D) Any percentile limiter applied to determine the appropriateness of an amount charged for a health service provided to an enrollee.
(8) Ensure that every provider referred to in subdivision (6) who makes medical claims review determinations or approves standards or guidelines for medical claims review determinations for the claim review agent has a current license
issued by a state licensing agency in the United States.
(9) Develop a medical claims review plan and file a summary of the plan with the department.


IC 27-8-16-8
Appeals procedure; written description; minimum standards; notice of appeal procedure on limitation or reduction of benefits

Sec. 8. (a) An insurance company, a health maintenance organization, or another benefit program providing payment, reimbursement, or indemnification for health care costs that contracts with a claim review agent for medical claims review services shall maintain and make available upon request a written description of the appeals procedure by which an enrollee may seek a review of a determination by the claim review agent.

(b) The appeals procedure referred to in subsection (a) must meet the following requirements:

   (1) On appeal, the determination must be made by a provider who holds a license in the same discipline as the provider who rendered the service.

   (2) The adjudication of an appeal of a determination must be completed within thirty (30) days after:
   (A) the appeal is filed; and
   (B) all information necessary to complete the appeal is received.

   (c) If a medical review determination results in a limitation or reduction of benefits, a notice of the appeals procedure shall be provided by the claim review agent to the provider who rendered the health care services.


IC 27-8-16-9
Provider's statement; documentation of review agent capability

Sec. 9. To provide documentation demonstrating that a claim review agent is capable of satisfying the requirement of section 7(6) of this chapter, the claim review agent must provide a signed statement of a provider employed by the claim review agent verifying that determinations are:

   (1) made by; or
   (2) determined in accordance with standards or guidelines approved by;

a provider licensed in the same discipline as the provider who rendered the service.


IC 27-8-16-9.5
Claim determinations based on data base information

Sec. 9.5. (a) As used in this section, "data base" means a data base that provides information concerning health care services or amounts
charged for health care services.

(b) If a claim review agent bases a medical claims review determination concerning a health care service provided by a hospital licensed under IC 12-25 or IC 16-21 in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(c) If a claim review consultant makes a recommendation or provides consultation concerning the appropriateness of or the amount charged for services provided by a hospital licensed under IC 12-25 or IC 16-21 based in whole or in part on information obtained from a data base, the information must relate exclusively to services provided by a hospital licensed under IC 12-25 or IC 16-21.

(d) This section does not apply to:
   (1) medical claims review determinations made under subsection (b); or
   (2) consultations or recommendations made under subsection (c);

regarding medical services provided under IC 22.


IC 27-8-16-10
Fraudulent or misleading information; penalties
Sec. 10. A provider, an enrollee, or an agent of a provider or enrollee who provides fraudulent or misleading information to a claim review agent is subject to the appropriate administrative, civil, and criminal penalties.


IC 27-8-16-11
Prohibited bases for compensation of claim review agents and consultants
Sec. 11. (a) The compensation of a claim review agent for the performance of medical claims review may not be based on the amount by which claims are reduced for payment.

(b) The compensation of a claim review consultant for making a recommendation or providing consultation concerning the appropriateness of or amount charged for a health care service delivered to an enrollee in Indiana may not be based on the amount by which a claim relating to the service is reduced for payment.


IC 27-8-16-12
Violations; claims review agent; notice; cease and desist orders; penalties; revocation or suspension of registration; review
Sec. 12. (a) If the department believes that a claim review agent or claim review consultant has violated this chapter, the department shall notify the claim review agent or claim review consultant of the alleged violation.
(b) The claim review agent or claim review consultant shall respond to a notice given under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:

(1) believes that a claim review agent or claim review consultant has violated this chapter; and

(2) is not satisfied, based on the response given by the claim review agent or claim review consultant under subsection (b), that the violation has been corrected;

the department shall order the claim review agent or claim review consultant under IC 4-21.5-3-6 to cease all claims review activities in Indiana.

(d) If the department determines that a claim review agent or claim review consultant has violated this chapter, the department:

(1) shall order the claim review agent or claim review consultant to cease and desist from engaging in the violation; and

(2) may do either or both of the following:

(A) Order the claim review agent or claim review consultant to pay a civil penalty of not more than five thousand dollars ($5,000) if the claim review agent or claim review consultant has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the claim review agent or claim review consultant.

e) An order issued or a ruling made by the department under this section is subject to review under IC 4-21.5.


IC 27-8-16-13
Confidential information

Sec. 13. (a) This chapter does not require a claim review agent or claim review consultant to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a claim review agent in conducting medical claims review; and

(2) other proprietary information concerning medical claims review conducted by a claim review agent;

that is disclosed to the department under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1).


IC 27-8-16-14
Rules

Sec. 14. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

IC 27-8-17
Chapter 17. Health Care Utilization Review

IC 27-8-17-1
"Covered individual" defined
Sec. 1. As used in this chapter, "covered individual" means:
(1) an enrollee; or
(2) an eligible dependent of an enrollee.

IC 27-8-17-2
"Department" defined
Sec. 2. As used in this chapter, "department" refers to the department of insurance.

IC 27-8-17-3
"Enrollee" defined
Sec. 3. As used in this chapter, "enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy issued under insurance classes 1(b) and 2(a) of IC 27-1-5-1, health maintenance organization contract, or other benefit program providing payment, reimbursement, or indemnification for the costs of health care for:
(1) the individual;
(2) eligible dependents of the individual; or
(3) both the individual and the individual's eligible dependents.

IC 27-8-17-4
"Health maintenance organization" defined
Sec. 4. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

IC 27-8-17-5
"Provider of record" defined
Sec. 5. As used in this chapter, "provider of record" means the physician or other licensed practitioner identified to a utilization review agent as having primary responsibility for the care, treatment, and services rendered to a covered individual.

IC 27-8-17-6
"Utilization review" defined
Sec. 6. (a) As used in this chapter, "utilization review" means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services provided or proposed to be provided to a covered individual.
(b) The term does not include the following:
   (1) Elective requests for clarification of coverage, eligibility, or benefits verification.
   (2) Medical claims review (as defined in IC 27-8-16-4).


IC 27-8-17-7
"Utilization review agent" defined

Sec. 7. (a) As used in this chapter, "utilization review agent" means any entity performing utilization review, except the following:
   (1) An agency of the state or federal government.
   (2) An agent acting on behalf of the federal or state government.
   (3) Entities conducting general in-house utilization review for hospitals, home health agencies, health maintenance organizations, preferred provider organizations or other managed care entities, clinics, private offices, or any other health facility, so long as the review does not result in the approval or denial of an enrollee's coverage for hospital or medical services.

(b) However, an agent described in subsection (a)(2) who performs utilization review for a person other than the federal or state government is a utilization review agent who is subject to the requirements of this chapter.

IC 27-8-17-8
"Utilization review determination" defined

Sec. 8. (a) As used in this chapter, "utilization review determination" means the rendering of a decision based on utilization review that denies or affirms either of the following:
   (1) The necessity or appropriateness of the allocation of resources.
   (2) The provision or proposed provision of health care services to a covered individual.

(b) The term does not include the identification of alternative, optional medical care that:
   (1) requires the approval of the covered individual; and
   (2) does not affect coverage or benefits if rejected by the covered individual.

IC 27-8-17-9
Certificate of registration; issuance to agent

Sec. 9. (a) A utilization review agent may not conduct utilization review in Indiana unless the utilization review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a utilization review agent must submit to the department an application containing the following:
   (1) The name, address, telephone number, and normal business
hours of the utilization review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the utilization review agent is capable of satisfying the minimum requirements set forth in section 11 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 10(a) of this chapter in the rules adopted under section 20 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out its responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a utilization review agent that satisfies the requirements of this section.


IC 27-8-17-10
Certificate of registration; renewal; transfer; notice of change in information

Sec. 10. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed on June 30 of each year. To obtain the renewal of a certificate of registration, a utilization review agent must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 9(d) of this chapter. The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the entity to whom the certificate is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the utilization review agent that submitted the application shall notify the department of the change in writing within thirty (30) days after the change.


IC 27-8-17-11
Minimum utilization review agent requirements

Sec. 11. A utilization review agent must satisfy the following
minimum requirements:
   (1) Provide toll free telephone access at least forty (40) hours each week during normal business hours.
   (2) Maintain a telephone call recording system capable of accepting or recording incoming telephone calls or providing instructions during hours other than normal business hours.
   (3) Respond to each telephone call left on the recording system maintained under subdivision (2) within two (2) business days after receiving the call.
   (4) Protect the confidentiality of the medical records of covered individuals.
   (5) Within two (2) business days after receiving a request for a utilization review determination that includes all information necessary to complete the utilization review determination, notify the enrollee or the provider of record of the utilization review determination by mail or another means of communication.
   (6) Include in the notification of a utilization review determination not to certify an admission, a service, or a procedure:
      (A) if the determination not to certify is based on medical necessity or appropriateness of the admission, service, or procedure, the principal reason for that determination; and
      (B) the procedures to initiate an appeal of the determination.
   (7) Ensure that every utilization review determination as to the necessity or appropriateness of an admission, a service, or a procedure is:
      (A) reviewed by a physician; or
      (B) determined in accordance with standards or guidelines approved by a physician.
   (8) Ensure that every physician making a utilization review determination for the utilization review agent has a current license issued by a state licensing agency in the United States.
   (9) Provide a period of at least forty-eight (48) hours following an emergency admission, service, or procedure during which:
      (A) an enrollee; or
      (B) the representative of an enrollee;
      may notify the utilization review agent and request certification or continuing treatment for the condition involved in the admission, service, or procedure.
   (10) Provide an appeals procedure satisfying the requirements set forth in section 12 of this chapter.
   (11) Develop a utilization review plan and file a summary of the plan with the department.


IC 27-8-17-12
Appeals procedure
Sec. 12. (a) A utilization review agent shall make available to an enrollee, and to a provider of record upon request, at the time an
adverse utilization review determination is made:
(1) a written description of the appeals procedure by which an enrollee or a provider of record may appeal the utilization review determination by the utilization review agent; and
(2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:
(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.
(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:
   (A) the appeal is filed; and
   (B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within forty-eight (48) hours after:
   (1) the appeal is initiated; and
   (2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28-1) or a contract issued by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.


IC 27-8-17-13
Physician's statement; documentation of review agent capability
Sec. 13. To provide documentation demonstrating that a utilization review agent is capable of satisfying the requirement of section 11(7) of this chapter, as required by section 9(b)(3) of this chapter, the utilization review agent may provide a signed statement of a physician employed by or under contract to the utilization review
agent verifying that determinations made by the utilization review agent as to the necessity or appropriateness of admissions, services, and procedures are reviewed by a physician or determined in accordance with standards or guidelines approved by a physician. 


**IC 27-8-17-14**

**Accreditation and approval of review agent; determination; new certificate of registration; order to cease activities**

Sec. 14. (a) The department may, according to the rules adopted under section 20 of this chapter, determine that a utilization review agent satisfies the requirements set forth in section 11 of this chapter if the utilization review agent:

(1) has, at the time of issuance of the agent's certificate of registration, received; and

(2) maintains;

the approval or accreditation of a utilization review accreditation organization that has been approved by the department for the purposes of this section. The department may not make a determination under this subsection before July 1, 1993.

(b) If a utilization review agent:

(1) is determined to satisfy the requirements of section 11 of this chapter by obtaining accreditation from a utilization review accreditation organization; and

(2) subsequently loses the accreditation from the accrediting organization;

the utilization review agent must, within sixty (60) days after losing its accreditation, obtain a new certificate of registration under this chapter to continue to conduct utilization review in Indiana. During the sixty (60) day period, the utilization review agent may continue to conduct utilization review subject to all other requirements of this chapter, unless ordered to cease under subsection (c).

(c) If the department determines, before the expiration of the sixty (60) day period referred to in subsection (b), that the utilization review agent cannot satisfy the requirements for issuance of a certificate of registration under this chapter, the department shall order the utilization review agent to immediately cease all utilization review activities in Indiana.


**IC 27-8-17-15**

**Certification of admission, service, or procedure; enrollee request; notice and information; assistance; denial under terms of benefit program**

Sec. 15. (a) The following requirements apply to an enrollee's request for certification by a utilization review agent of an admission, a service, or a procedure:

(1) In the absence of contractual terms to the contrary, the enrollee is responsible for notifying the utilization review agent of the admission, service, or procedure in a timely manner and
for obtaining certification of health care services.
(2) A utilization review agent shall allow the provider of record or a responsible patient representative, including a family member, to assist the enrollee in fulfilling the enrollee's responsibility under subdivision (1).
(3) The provider of record shall, within a reasonable time, provide to the utilization review agent all relevant information necessary to certify the admission, service, or procedure. For an emergency admission or procedure, the information shall be provided within two (2) business days after the emergency admission or procedure. For an elective admission, procedure, or treatment, the information shall be provided not later than two (2) business days before the admission or the provision of the procedure or treatment.

(b) The failure to provide the information required by this section may result in the denial of certification in accordance with the terms of the enrollee's insurance policy, health maintenance organization contract, or other benefit program.


IC 27-8-17-16
Fraudulent or misleading information; penalties
Sec. 16. A provider of record, an enrollee, or the agent of a provider of record or an enrollee who provides fraudulent or misleading information is subject to appropriate administrative, civil, and criminal penalties, including the penalty for deception under IC 35-43-5-3.


IC 27-8-17-17
Violations; notice to agent; cease and desist orders; penalties; revocation or suspension of registration; review
Sec. 17. (a) If the department believes that a utilization review agent has violated this chapter, the department shall notify the utilization review agent of the alleged violation.

(b) The utilization review agent shall respond to a notice given under subsection (a) within thirty (30) days after receiving the notice.

(c) If the department:
(1) believes that a utilization review agent has violated this chapter; and
(2) is not satisfied, based on the response given by the utilization review agent under subsection (b), that the violation has been corrected;
the department shall order the utilization review agent under IC 4-21.5-3-6 to cease all utilization review activities in Indiana.

(d) If the department determines that a utilization review agent has violated this chapter, the department:
(1) shall order the utilization review agent to cease and desist from engaging in the violation; and
(2) may do either or both of the following:
(A) Order the utilization review agent to pay a civil penalty of not more than five thousand dollars ($5,000) if the utilization review agent has committed violations with a frequency that indicates a general business practice.

(B) Suspend or revoke the certificate of registration of the utilization review agent.

(e) Any order issued or ruling made by the department under this section is subject to review under IC 4-21.5.


IC 27-8-17-18
Confidential information
Sec. 18. (a) This chapter does not require a utilization review agent to disclose information that is proprietary.

(b) Any:

(1) information concerning standards, criteria, or medical protocols used by a utilization review agent in conducting utilization review; or

(2) other proprietary information concerning utilization review conducted by a utilization review agent;

that is disclosed to the department of insurance under this chapter is confidential for the purposes of IC 5-14-3-4(a)(1) and may not be disclosed by the department.


IC 27-8-17-19
Prohibited bases for compensation of agent
Sec. 19. The compensation of a utilization review agent for the performance of utilization review may not be based on:

(1) the extent to which certifications are denied; or

(2) the amount by which subsequent claims are reduced for payment.


IC 27-8-17-20
Rules
Sec. 20. The department shall adopt rules under IC 4-22-2 necessary to carry out this chapter.

IC 27-8-18
Chapter 18. Charitable Entity's Insurable Interest in Life of Donor

IC 27-8-18-1
Application of chapter
Sec. 1. This chapter applies to every life insurance policy issued in Indiana or issued for delivery in Indiana, irrespective of the date of issue.

IC 27-8-18-2
"Charitable entity" defined
Sec. 2. As used in this chapter, "charitable entity" means an entity that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code.

IC 27-8-18-3
"Life insurance policy" defined
Sec. 3. As used in this chapter, "life insurance policy" means an insurance policy that provides the type of insurance described in Class 1(a) of IC 27-1-5-1.

IC 27-8-18-4
Purchase, ownership, or transfer of ownership; consent; insurable interest
Sec. 4. (a) A charitable entity may:
(1) purchase;
(2) own; or
(3) be transferred ownership of;
a life insurance policy on the life of an individual if the individual consents to the charitable entity's purchase or ownership of the policy.
(b) A charitable entity that purchases or is transferred ownership of a life insurance policy under subsection (a) has an insurable interest in the life of the individual who consents to the charitable entity's purchase or ownership of the policy.

IC 27-8-18-5
Inquiry into legal status of charitable entity
Sec. 5. A life insurance company that is requested to:
(1) issue a life insurance policy; or
(2) transfer ownership of a life insurance policy;
to an entity that is purported to be a charitable entity has no obligation to inquire into the legal status of that entity under any law.
IC 27-8-18-6

Reliance on good faith representations

Sec. 6. A life insurance company is entitled to rely on the representations made in apparent good faith by the owner or putative owner of a life insurance policy for the purpose of inducing the life insurance company to accept an entity as the owner or beneficiary of the life insurance policy.

IC 27-8-19
Repealed
(Repealed by P.L.1-1994, SEC.137.)
IC 27-8-19.8
Chapter 19.8. Viatical Settlements

IC 27-8-19.8-1
"Applicant" defined
Sec. 1. As used in this chapter, "applicant" refers to a person that applies for a viatical settlement provider license under this chapter.

IC 27-8-19.8-2
"Department" defined
Sec. 2. As used in this chapter, "department" refers to the department of insurance.

IC 27-8-19.8-3
"Insured" defined
Sec. 3. As used in this chapter, "insured" refers to an individual whose life is the subject of insurance under a life insurance policy or contract.

IC 27-8-19.8-4
Repealed
(Repealed by P.L.32-1998, SEC.32.)

IC 27-8-19.8-4.3
"Viatical settlement agent" defined
Sec. 4.3. As used in this chapter, "viatical settlement agent" means a person that solicits, offers, or attempts to negotiate a viatical settlement contract with a viator.

IC 27-8-19.8-4.5
"Viatical settlement broker" defined
Sec. 4.5. As used in this chapter, "viatical settlement broker" means a person that represents a viator and for a fee, commission, or other valuable consideration, solicits, offers, or attempts to negotiate viatical settlements between a viator and one (1) or more viatical settlement providers.

IC 27-8-19.8-5
"Viatical settlement provider" defined
Sec. 5. (a) As used in this chapter, "viatical settlement provider" means a person, other than a viator, that:
(1) enters into a viatical settlement contract with a viator; or
(2) obtains financing for the purchase, acquisition, transfer, or
other assignment of one (1) or more viatical settlement contracts, viaticated policies, or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates, or disposes of one (1) or more viatical settlement contracts, viaticated policies, or interests therein.

(b) The term does not include any of the following:
   (1) A bank, savings bank, savings association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan.
   (2) The issuer of a life insurance policy that makes a policy loan, permits surrender of the policy, or pays other policy benefits, including accelerated benefits, in accordance with the terms of the policy.


IC 27-8-19.8-6
"Viatical settlement contract" defined
Sec. 6. As used in this chapter, "viatical settlement contract" means an agreement for the purchase, sale, assignment, transfer, devise, or bequest of a portion of the death benefit or ownership of a life insurance policy or contract for consideration that is less than the expected death benefit of the life insurance policy or contract. The term does not include the following:
   (1) A loan by an insurer under the terms of a life insurance policy, including a loan secured by the cash value of a policy.
   (2) An agreement with a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan.
   (3) The provision of accelerated death benefits by an insurer to an insured under the provisions of a life insurance contract.
   (4) Agreements between an insurer and a reinsurer.
   (5) An agreement by a person who enters into not more than one such agreement in any five (5) year period to purchase a life insurance policy or contract for a value that is less than the expected death benefit.


IC 27-8-19.8-6.5
"Viaticated policy" defined
Sec. 6.5. As used in this chapter, "viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider under a viatical settlement contract.


IC 27-8-19.8-7
"Person" defined
Sec. 7. As used in this chapter, "person" means an individual, an
association, a corporation, a limited liability corporation, an estate, a partnership, a trust, or any other business or legal entity.


IC 27-8-19.8-7.8
"Stranger originated life insurance" defined
Sec. 7.8. (a) As used in this chapter, "stranger originated life insurance" means a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time the life insurance policy is originated, has no insurable interest in the insured.

(b) The term includes the following:
(1) An arrangement under which, at the time of life insurance policy inception:
   (A) a life insurance policy is purchased with resources or guarantees from or through a person that is not legally permitted to initiate the life insurance policy; and
   (B) a written or verbal arrangement or agreement is made to transfer the ownership of the life insurance policy or policy benefits to a third party.

(2) A trust that is:
   (A) created to give an appearance of the existence of an insurable interest; and
   (B) used to initiate a life insurance policy for an investor.

As added by P.L.112-2008, SEC.3.

IC 27-8-19.8-8
"Viator" defined
Sec. 8. As used in this chapter, "viator" refers to the owner of a life insurance policy or a certificate holder under a group policy that insures the life of an insured who enters or seeks to enter into a viatical settlement contract.


IC 27-8-19.8-8.5
Persons required to be licensed as insurance producer with life qualification
Sec. 8.5. The following must be licensed as an insurance producer with a life qualification under IC 27-1-15.6-7:

(1) A viatical settlement broker.

(2) A person who solicits, offers, or attempts to negotiate a viatical settlement contract with a viator.


IC 27-8-19.8-8.6
Exemptions from licensing requirement
Sec. 8.6. The following are exempt from the licensing requirement under IC 27-8-19.8-8.5:
(1) An accountant, an attorney, or a financial planner retained to represent the viator, and whose compensation is paid directly by or at the direction of the viator.
(2) A regularly salaried officer or employee of a viatical settlement broker or viatical settlement provider, if the officer or employee's duties and responsibilities do not include the solicitation or negotiation of viatical settlement contracts.
(3) The following persons, to the extent that the person is engaged in the administration or operation of a program of employee benefits for the person's employees or the employees of the person's subsidiaries or affiliates involving the use of viatical settlement contracts issued by a licensed viatical settlement provider, if the person is not in any manner directly or indirectly compensated by the viatical settlement provider:
   (A) An employer.
   (B) An officer or employee of an employer.
   (C) A trustee of an employee trust plan.


**IC 27-8-19.8-8.7**

Fiduciary duties of viatical settlement brokers

Sec. 8.7. A viatical settlement broker:
   (1) represents only the viator; and
   (2) owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator; regardless of the manner in which the viatical settlement broker is compensated.


**IC 27-8-19.8-9**

License required for viatical settlement providers

Sec. 9. After December 31, 1998, a person may not act as a viatical settlement provider unless the person holds an unexpired license issued under this chapter.


**IC 27-8-19.8-9.2**

Insurance producer remuneration

Sec. 9.2. An insurance producer that:
   (1) is licensed under IC 27-1-15.6; and
   (2) sells a life insurance policy or contract that, less than two (2) years after the insurance producer sells the policy or contract, is the subject of a viatical settlement contract;
shall not accept a commission or other remuneration in connection with the viatical settlement contract.

As added by P.L.223-2005, SEC.5.

**IC 27-8-19.8-10**

Application and fee for license
Sec. 10. (a) An applicant must do the following to obtain a license as a viatical settlement provider:

(1) Apply for the license on forms prescribed by the department.
(2) Provide information required by the department.
(3) Pay the license fee.

(b) The application must include the name of each officer, member, or employee of the applicant who will be authorized by the applicant to act as a viatical settlement provider under the license if issued to the applicant.

(c) The department shall adopt rules under IC 4-22-2 to set the licensing fee required by this section.


IC 27-8-19.8-11
Investigation of applicant; issuance of license

Sec. 11. The department shall investigate an applicant and issue a license to the applicant if the department finds all of the following:

(1) The applicant is competent and trustworthy and intends to act in good faith as a viatical settlement provider.
(2) The applicant has a good business reputation.
(3) The applicant has had the experience, training, or education to qualify the applicant as a viatical settlement provider.
(4) If the applicant is a corporation, or limited liability corporation, it is either:
   (A) incorporated under Indiana law; or
   (B) authorized to do business in Indiana.


IC 27-8-19.8-12
Refusal to issue license

Sec. 12. The department may refuse to issue a license to an applicant if the department is not satisfied that any officer, employee, partner, or stockholder who could materially influence the applicant's conduct meets the standards of this chapter.


IC 27-8-19.8-13
Nonresident licenses

Sec. 13. The department may not issue a license to an applicant who is not an Indiana resident unless the applicant does either of the following:

(1) Files and maintains with the department a written designation of an agent for service of process.
(2) Files with the department the applicant's written irrevocable consent that any action against the applicant may be begun against the applicant by the service of process on the department.

IC 27-8-19.8-14
Individuals authorized to act as viatical settlement benefits providers
Sec. 14. A license issued under this chapter authorizes all officers, members, and employees of the license holder designated under section 10(b) of this chapter to act as viatical settlement providers under the license.

IC 27-8-19.8-15
Expiration and renewal of license
Sec. 15. (a) A license issued or renewed under this chapter expires on July 1 after its issuance or renewal.
(b) A viatical settlement provider may renew a license by:
   (1) applying for renewal on forms prescribed by the department; and
   (2) paying the renewal fee.
(c) The department shall adopt rules under IC 4-22-2 to do the following:
   (1) Set the renewal fee required by this section.
   (2) Set a date before July 1 and before which receipt of a license renewal application can be processed without a lapse in the license.
(d) A viatical settlement provider that submits an application for renewal after the date set under subsection (c)(2):
   (1) is not entitled to have the license renewed before July 1; and
   (2) may not act as a viatical settlement provider until the department issues the license renewal, if the department is unable to process the renewal before July 1.

IC 27-8-19.8-16
Disclosure of identity of individuals associated with viatical settlement providers
Sec. 16. The department may at any time require a viatical settlement provider or an applicant for a license to disclose fully the identity of all of the viatical settlement provider's or applicant's officers, employees, partners, and stockholders.

IC 27-8-19.8-17
Annual reports
Sec. 17. (a) A viatical settlement provider shall file with the department an annual report containing information prescribed in rules adopted by the department under IC 4-22-2.
(b) The rules adopted by the department under subsection (a) shall set the date by which annual reports must be submitted.

IC 27-8-19.8-18
Examination of viatical settlement provider or applicant
Sec. 18. (a) When the department reasonably considers it necessary for the protection of the public, the department may examine the business and other affairs of a viatical settlement provider or an applicant.

(b) The department may order a viatical settlement provider or an applicant to produce records, books, files, or other information reasonably necessary to ascertain whether the viatical settlement provider or the applicant has violated or is violating the law or otherwise has acted or is acting contrary to the public interest.


IC 27-8-19.8-19
Suspension, revocation, or refusal to renew license
Sec. 19. After a hearing under IC 4-21.5, the department may suspend, revoke, or refuse to renew a viatical settlement provider's license, or impose a civil penalty, or both, if the department finds any of the following:

(1) There was a misrepresentation in the application for the license.
(2) The viatical settlement provider is untrustworthy or incompetent to act as a viatical settlement provider.
(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators.
(4) The viatical settlement provider has been convicted of, or pleaded guilty or nolo contendere to, an offense the definition of which includes fraudulent acts as an element of the offense regardless of whether a judgment has been entered by the court.
(5) The viatical settlement provider no longer meets the requirements for initial licensure.
(6) The viatical settlement provider has failed to honor the contractual obligations of a viatical settlement contract.

IC 27-8-19.8-20
Repealed
(Repealed by P.L.32-1998, SEC.32.)
IC 27-8-19.8-20.1
Stranger originated life insurance; prohibition
   Sec. 20.1. (a) A person shall not issue, solicit, market, or otherwise promote the purchase of a life insurance policy in connection with stranger originated life insurance.
   (b) A violation of this section is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.
   As added by P.L.112-2008, SEC.4.

IC 27-8-19.8-21
Required terms of viatical settlement contract
   Sec. 21. (a) A viatical settlement contract must establish the terms under which the viatical settlement provider will pay value, in return for the viator's assignment, bequest, devise, sale, or transfer of the death benefit, certificate, or ownership of the insurance policy to the viatical settlement provider.
   (b) A viatical settlement contract must provide for the unconditional rescission of the contract by the viator for the longer of the following:
       (1) the period ending not more than fifteen (15) days after the receipt of the viatical settlement proceeds by the viator; or
       (2) the period ending not more than thirty (30) days after execution of the contract.
   (c) A viatical settlement contract is rescinded if the insured dies during the rescission period, subject to repayment to the viatical settlement provider of all proceeds and any premiums, loans, and loan interest that have been paid by the viatical settlement provider.

IC 27-8-19.8-22
Form for viatical settlement contract
   Sec. 22. (a) A person may not use a viatical settlement contract form or a disclosure form in Indiana unless the contract form or disclosure form has been filed with and approved by the department.
   (b) A viatical settlement contract form or disclosure form filed with the department is considered approved if the department has not disapproved the form within sixty (60) days after the filing.
   (c) The department shall disapprove a viatical settlement contract form or disclosure form if the department finds that the contract form, disclosure form, or the provisions of the contract are:
       (1) misleading or unfair to the viator;
       (2) not in compliance with this chapter; or
       (3) otherwise contrary to the public interest.

IC 27-8-19.8-23
Required disclosures to viator; information to insured
   Sec. 23. (a) A viatical settlement provider or viatical settlement
broker shall, not later than the date of application, provide to a viator a brochure approved by the commissioner and describing the viatical settlement process. If a brochure describes only a viatical settlement contract in which the insured does not have a catastrophic or life threatening illness or condition, the brochure may use the term "life settlement" in place of the term "viatical settlement".

(b) A viatical settlement provider or viatical settlement broker shall, in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, disclose the following information to the viator not later than the date of application:

1. Possible alternatives to viatical settlement contracts, including accelerated benefits or policy loans offered by the issuer of the life insurance policy.

2. Federal and state tax consequences that may result from entering into a viatical settlement contract, and that the viator should seek assistance from a professional tax advisor.

3. Possible:
   - (A) adverse effect on eligibility for; or
   - (B) interruption of assistance provided by;
   medical or public assistance programs as a consequence of entering into a viatical settlement contract, and that the viator should seek advice from the appropriate government agencies.

4. The viator's right to rescind a viatical settlement contract as provided in section 21 of this chapter.

5. The amount of any fees paid by a viatical settlement provider to a viatical settlement broker.

6. A statement that proceeds of the viatical settlement could be subject to claims of creditors.

7. A statement that:
   - (A) entering into a viatical settlement contract may cause other rights or benefits under the policy, including conversion rights, waiver of premium benefits, family riders, or coverage of a life other than the insured, to be forfeited by the viator; and
   - (B) the viator should seek advice from a financial advisor.

8. The procedure for contacts with the insured.

9. That the proceeds of the viatical settlement will be transferred to the viator as provided in section 24.2 of this chapter.

10. A statement containing the following language:
    "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the
policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.

(11) That the insured may be contacted by the viatical settlement provider or viatical settlement broker to determine the health status of the insured in accordance with section 24.9 of this chapter.

(c) The viatical settlement provider shall disclose the following information to the viator, conspicuously displayed in the viatical settlement contract or in a separate document signed by the viatical settlement provider and the viator, before a viatical settlement contract is signed:

(1) Any affiliation between the viatical settlement provider and the insurer that issued the life insurance policy or certificate that is the subject of the viatical settlement contract.

(2) The name, address, and telephone number of the viatical settlement provider.

(3) If the life insurance policy or certificate that is the subject of the viatical settlement contract was issued as a joint policy or includes family riders or any coverage of an individual other than the insured:

(A) the possible loss of coverage of the other individuals under the policy or certificate; and

(B) that the viator should consult with the viator's insurance producer or the insurer that issued the policy or certificate for advice concerning the proposed viatical settlement contract.

(4) The:

(A) dollar amount of the current death benefit payable to the viatical settlement provider; and

(B) if known, the:

(i) availability of any additional guaranteed insurance benefits;

(ii) dollar amount of any accidental death and dismemberment benefits; and

(iii) viatical settlement provider's interest in the benefits described in items (i) and (ii); under the policy or certificate.

(5) The:

(A) name, business address, and telephone number of the trustee or escrow agent described in section 24.2 of this chapter; and

(B) right of the viator or insured to inspect or receive copies of the relevant escrow or trust agreements or documents.

(d) A viatical settlement broker shall disclose to the viator, conspicuously displayed in the viatical settlement contract or in a separate document signed by the viatical settlement broker and the viator before a viatical settlement contract is signed, the amount and method of calculation of the viatical settlement broker's compensation.

(e) If a viatical settlement provider transfers ownership or changes
the beneficiary of a viaticated policy, the viatical settlement provider shall, not more than twenty (20) days after the transfer or change occurs, inform the insured of the transfer or change.


**IC 27-8-19.8-24**

**Prerequisites to viatical settlement contract**

Sec. 24. A viatical settlement provider shall obtain the following before entering into a viatical settlement contract:

1. If the viator is the insured, a written statement from a licensed attending physician that the insured is of sound mind and under no constraint or undue influence.
2. A document signed by the viator and witnessed by two (2) disinterested witnesses in which the viator does the following:
   A. Consents to the viatical settlement contract.
   B. If the insured has a catastrophic or life threatening illness or condition, acknowledges the catastrophic or life threatening illness or condition.
   C. Represents that the viator has a full and complete understanding of the viatical settlement contract.
   D. Represents that the viator has a full and complete understanding of the benefits of the life insurance policy.
   E. Acknowledges that the viator has entered into the viatical settlement contract freely and voluntarily.
   F. Discloses the identity of any person that served as a viatical settlement broker in connection with the viatical settlement contract.
3. A document in which the insured consents to the release of the insured's medical records.


**IC 27-8-19.8-24.2**

**Payment of proceeds of settlement to trust or escrow account; transfer of proceeds of settlement to viator**

Sec. 24.2. (a) Immediately upon a viatical settlement provider's receipt of a signed viatical settlement contract, the viatical settlement provider shall pay the proceeds of the viatical settlement to a trust or escrow account in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. The account shall be managed by a trustee or escrow agent independent of the parties to the contract.

(b) Within two (2) business days after the viatical settlement provider's receipt of the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated according to the viatical settlement contract, the trustee or escrow agent shall transfer the proceeds to the viator.

IC 27-8-19.8-24.7
Disclosure of identity of viator
Sec. 24.7. Except as otherwise provided by law, a person with actual knowledge of a viator's identity may not disclose that identity to another person unless the disclosure is:
(1) necessary to effect a viatical settlement contract and the viator has provided written consent to the disclosure;
(2) provided in response to an investigation by the commissioner or other governmental officer or agency; or
(3) in connection with a transfer of a viatical settlement contract or viaticated policy to another licensed viatical settlement provider or to an entity that provides financing to effect the viatical settlement contract under a written agreement with a licensed viatical settlement provider.
As added by P.L.32-1998, SEC.27.

IC 27-8-19.8-24.8
Applicability of IC 16-39 to release of insured's medical records
Sec. 24.8. IC 16-39 applies to the release of an insured's medical records under this chapter.

IC 27-8-19.8-24.9
Contacts with insured for purpose of determining health status
Sec. 24.9. (a) The viatical settlement provider or viatical settlement broker may contact the insured for the purpose of determining the health status of the insured not more than:
(1) one (1) time every three (3) months for an insured with a life expectancy of more than one (1) year; or
(2) one (1) time every month for an insured with a life expectancy of not more than one (1) year.
(b) Contacts made with an insured under subsection (a) must be made by mail unless the parties agree to another method of contact.

IC 27-8-19.8-25
Standards for evaluation of reasonableness of payments under viatical settlement contract
Sec. 25. The department may adopt rules under IC 4-22-2 to establish standards for evaluating the reasonableness of payments under viatical settlement contracts, including regulation of discount rates used to determine the amount paid in exchange for an assignment, a bequest, a devise, a sale, or a transfer of a benefit under a life insurance policy.

IC 27-8-19.8-26
Adoption of rules
Sec. 26. The department may adopt rules under IC 4-22-2 that the
department considers necessary to implement this chapter.
IC 27-8-20  
Chapter 20. Reimbursement for Off Label Drug Treatment

IC 27-8-20-0.1  
Application of chapter  
Sec. 0.1. The addition of this chapter by P.L.277-1993(ss) applies to insurance policies or health maintenance contracts that:  
(1) are entered into or renewed with employers or individuals; and  
(2) become effective after June 30, 1993.  
As added by P.L.220-2011, SEC.448.

IC 27-8-20-1  
"Commissioner" defined  
Sec. 1. As used in this chapter, "commissioner" refers to the commissioner of the department of insurance.  
As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-2  
"Drug" defined  
Sec. 2. As used in this chapter, "drug" means a drug or biologic that is used in an anticancer chemotherapeutic regimen.  
As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-3  
"Insurance policy" defined  
Sec. 3. As used in this chapter, "insurance policy" means an accident and sickness policy (as defined in IC 27-8-5-1).  
As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-4  
"Off label use" defined  
Sec. 4. As used in this chapter, "off label use" means the use of a drug for indications other than those stated in the labeling approved by the federal Food and Drug Administration.  
As added by P.L.277-1993(ss), SEC.120.

IC 27-8-20-5  
"Health maintenance organization" defined  
Sec. 5. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.  

IC 27-8-20-6  
"Standard reference compendium" defined  
Sec. 6. As used in this chapter, "standard reference compendium" means any of the following:  
(1) The United States Pharmacopeia Drug Information.  
(2) The American Medical Association Drug Evaluations.
IC 27-8-20-7
Exclusion of coverage for drugs not approved by the FDA; limitations
Sec. 7. An insurance policy or a health maintenance organization that provides coverage for drugs may not exclude coverage of a covered drug for a particular indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for the particular indication if any of the following conditions are met:

(1) The drug is recognized for treatment of the indication in at least one (1) standard reference compendium.
(2) The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.


IC 27-8-20-8
Enforcement of chapter
Sec. 8. The commissioner has the authority to enforce this chapter under the provisions of IC 27-1-3-19, IC 27-9, and IC 27-13.


IC 27-8-20-9
Drugs not requiring coverage; drug's use contraindicated; experimental drugs; alteration of laws limiting coverage on drugs not approved by the FDA
Sec. 9. This chapter does not do any of the following:

(1) Require coverage for any drug when the federal Food and Drug Administration has determined the drug's use to be contraindicated.
(2) Require coverage for an experimental drug not approved for any indication by the federal Food and Drug Administration.
(3) Alter any other law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration.

As added by P.L.277-1993(ss), SEC.120.
IC 27-8-21
Chapter 21. Advertisements Concerning Interest Rate Guarantees

IC 27-8-21-1
Applicability of chapter
Sec. 1. This chapter applies to an advertisement that is broadcast, published, or otherwise presented to the general public in Indiana. 

IC 27-8-21-2
Statement of period of interest rate guarantee required
Sec. 2. An advertisement that refers to an interest rate guarantee applying to a life insurance product or to an annuity contract must state the period for which the interest rate is guaranteed. 

IC 27-8-21-3
Violation an unfair or deceptive act or practice
Sec. 3. The presentation to the general public of an advertisement that violates section 2 of this chapter is an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4. 
IC 27-8-22
  Chapter 22. Patient Billing

IC 27-8-22-1
"Health care provider" defined
  Sec. 1. As used in this chapter, "health care provider" has the
meaning set forth in IC 34-18-2-14.
As added by P.L.1-1994, SEC.139. Amended by P.L.1-1998,
SEC.152; P.L.1-2010, SEC.112.

IC 27-8-22-2
"Claim information" defined
  Sec. 2. As used in this chapter, "claim information" means the
following:
  (1) A notice that a claim has been filed with a patient's third
  party payor.
  (2) A copy of an itemized bill for services when submitted to the
  third party payor.
As added by P.L.1-1994, SEC.139.

IC 27-8-22-3
"Representative" defined
  Sec. 3. As used in this chapter, "representative" has the meaning
set forth in IC 16-36-1-2.
As added by P.L.1-1994, SEC.139.

IC 27-8-22-4
Providing copy of claim information to patient
  Sec. 4. (a) A health care provider shall routinely provide to a
patient or the patient's representative, upon request, a copy of the
claim information for health care services to the patient that the
health care provider submits to the patient's insurance company,
Medicare, or other third party payor except Medicaid.
  (b) A health care provider is not required by this section to provide
the patient with more than one (1) copy of a patient's claim
information.
As added by P.L.1-1994, SEC.139.
IC 27-8-22.1
Chapter 22.1. Claims

IC 27-8-22.1-1
"Accident and sickness insurance policy" defined
Sec. 1. As used in this chapter, "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), 2(a), 2(b), 2(e), 2(f), and 2(h).

IC 27-8-22.1-2
"Insurer" defined
Sec. 2. As used in this chapter, "insurer" means:
(1) an insurer that issues:
   (A) an accident and sickness insurance policy; or
   (B) a worker's compensation policy; or
(2) an employer who has received a certificate from the worker's compensation board to carry the employer's worker's compensation risk without insurance under IC 22-3-2-5.

IC 27-8-22.1-3
"Provider" defined
Sec. 3. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

IC 27-8-22.1-4
"Worker's compensation policy" defined
Sec. 4. As used in this chapter, "worker's compensation policy" means a policy of insurance issued to an employer under IC 22-3-2-5.

IC 27-8-22.1-5
Use of diagnostic or procedure codes
Sec. 5. (a) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:
(1) an insurer shall begin using the most current version of the:
   (A) current procedural terminology (CPT);
   (B) international classification of diseases (ICD);
   (C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
   (D) current dental terminology (CDT);
   (E) Healthcare common procedure coding system (HCPCS); and
   (F) third party administrator (TPA); codes under which the insurer pays claims for services provided under an accident and sickness insurance policy or a worker's compensation policy; and
(2) a provider shall begin using the most current version of the:
   (A) current procedural terminology (CPT);
   (B) international classification of diseases (ICD);
   (C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);
   (D) current dental terminology (CDT);
   (E) Healthcare common procedure coding system (HCPCS);
   and
   (F) third party administrator (TPA);
   codes under which the provider submits claims for payment for services provided under an accident and sickness insurance policy or a worker's compensation policy.

(b) If a provider provides services that are covered under an accident and sickness insurance policy or a worker's compensation policy:
   (1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (a); and
   (2) before the insurer begins using the most current version of the diagnostic or procedure code;
   the insurer shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

IC 27-8-23
Chapter 23. Medical Child Support Provisions of Title XIX of the Federal Social Security Act

IC 27-8-23-1
Applicable provisions
Sec. 1. IC 12-15-29-9 and IC 12-15-29-10 apply to this chapter. 

IC 27-8-23-2
Applicability of chapter
Sec. 2. Notwithstanding any other law, this chapter applies to the duty of an insurer to provide family health coverage to a child in accordance with this chapter. 

IC 27-8-23-3
"Child" defined
Sec. 3. As used in this chapter, "child" refers to a child who is less than eighteen (18) years of age. 

IC 27-8-23-4
"Insurer" defined
Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 12-7-2-120. 

IC 27-8-23-5
Prohibited grounds for denial of coverage
Sec. 5. An insurer may not deny enrollment of a child under the health coverage of the child's parent on any of the following grounds:
   (1) That the child was born out of wedlock.
   (2) That the child is not claimed as a dependent on the parent's federal income tax return.
   (3) That the child does not reside:
       (A) with the parent; or
       (B) in the insurer's service area. 

IC 27-8-23-6
Duties of insurer to noncustodial parent
Sec. 6. Whenever a child has health coverage through an insurer of a noncustodial parent, the insurer shall:
   (1) provide any information to the custodial parent that is necessary for the child to obtain benefits through the coverage;
   (2) permit the custodial parent, or the provider of medical assistance services with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
(3) make payments on insurance claims submitted under subdivision (2) directly to the:
   (A) custodial parent;
   (B) provider of the medical assistance services; or
   (C) office of Medicaid policy and planning.


IC 27-8-23-7
Duties of insurer when parent is ordered to provide coverage for child
Sec. 7. Whenever a parent is required by a court or an administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, the insurer:
   (1) shall permit the parent to enroll under the family coverage a child who is otherwise eligible for the coverage, without regard to any enrollment season restrictions;
   (2) shall enroll a child under the family coverage upon application by:
      (A) the child's custodial parent;
      (B) the office of Medicaid policy and planning; or
      (C) a Title IV-D agency;
      whenever a noncustodial parent who is enrolled fails to apply for coverage of the child; and
   (3) may not disenroll or eliminate coverage of a child who is otherwise eligible for coverage unless the insurer is provided satisfactory written evidence that:
      (A) the court order or an administrative order is no longer in effect; or
      (B) the child is or will be enrolled in comparable health coverage through another insurer that is to take effect not later than the effective date of the disenrollment.


IC 27-8-23-8
Requirements imposed by insurer
Sec. 8. An insurer may not impose requirements on a state agency that has been assigned the rights of a person:
   (1) eligible for assistance under Medicaid; and
   (2) covered for health benefits from the insurer; that are different from requirements applicable to an agency or assignee of any other person who is covered.


IC 27-8-23-9
Delivery of policy
Sec. 9. A policy of health care coverage shall not be delivered or issued for delivery to any person in Indiana unless the policy complies with this chapter.

IC 27-8-24
Chapter 24. Minimum Maternity Benefits

IC 27-8-24-1
Applicability of chapter
Sec. 1. This chapter applies to:
(1) every policy of accident and sickness insurance (as defined in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, or a blanket basis; and
(2) every group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services;
that is issued, delivered, executed, or renewed in Indiana and that provides maternity benefits.

IC 27-8-24-2
"At-home postdelivery care" defined
Sec. 2. As used in this chapter, "at-home postdelivery care" refers to health care provided to a woman at her residence by a physician licensed under IC 25-22.5 or a registered nurse or an advanced practice nurse licensed under IC 25-23 whose scope of practice includes providing postpartum care in the area of maternal and child health care. The health care services provided must include, at a minimum:
(1) parent education;
(2) assistance and training in breast or bottle feeding; and
(3) performance of any maternal and neonatal tests routinely performed during the usual course of inpatient care for the woman or her newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

IC 27-8-24-3
"Maternity benefits" defined
Sec. 3. As used in this chapter, "maternity benefits" refers to the provision of health care to a woman before, during, and after delivery of a child, including physician, hospital, laboratory, and ultrasound services.

IC 27-8-24-4
Postpartum hospital stay; HIV testing of newborns; payment
Sec. 4. (a) Except as provided in section 5 of this chapter, every policy or group contract that provides maternity benefits must provide minimum benefits to a mother and her newborn child that cover:
(1) a minimum length of postpartum stay at a hospital licensed
under IC 16-21 that is consistent with the minimum postpartum hospital stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care; (2) the examinations to the newborn child required under IC 16-41-17-2; and (3) the testing of the newborn child required under IC 16-41-6-4.

(b) Payment to a hospital for a test required under IC 16-41-6-4 must be in an amount equal to the hospital's actual cost of performing the test.


IC 27-8-24-5
Conditions warranting shorter period of inpatient care; at-home postdelivery care visit

Sec. 5. (a) If the patients’ attending physician determines further inpatient care is not necessary for the mother or newborn child, a policy or group contract that provides maternity benefits under this chapter may provide under the policy or group contract a shorter length of postpartum hospital stay than the period under section 4 of this chapter if all the following conditions are met:

(1) in the patients' attending physician's opinion the newborn meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

(A) the antepartum, intrapartum, and postpartum course of the mother and infant;
(B) the gestational stage, birth weight, and clinical condition of the infant;
(C) the demonstrated ability of the mother to care for the infant after discharge; and
(D) the availability of postdischarge follow-up to verify the condition of the infant after discharge; and

(2) the policy or contract authorizes for the mother and the newborn one (1) at-home postdelivery care visit described in subsection (b).

(b) The at-home postdelivery care visit shall be conducted not later than forty-eight (48) hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.

(c) The provider of the policy or group contract described in this chapter shall provide notice to each enrollee under the policy or group contract regarding the coverage provided under this chapter.

IC 27-8-24.1
Chapter 24.1. Coverage for Treatment of Inherited Metabolic Disease

IC 27-8-24.1-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.166-2003 applies to an accident and sickness insurance policy that is issued, delivered, amended, or renewed after December 31, 2003.
As added by P.L.220-2011, SEC.449.

IC 27-8-24.1-1
"Accident and sickness insurance policy"
Sec. 1. (a) As used in this chapter, "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.
(b) 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) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy.
(6) A short term insurance plan that:
   (A) may not be renewed; and
   (B) has a duration of not more than six (6) months.
(7) 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.
(8) A supplemental plan that always pays in addition to other coverage.
(9) A student health plan.
(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.

IC 27-8-24.1-2
"Covered individual"
Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to coverage under an accident and sickness insurance policy.
As added by P.L.166-2003, SEC.2.
IC 27-8-24.1-3
"Inherited metabolic disease"
Sec. 3. As used in this chapter, "inherited metabolic disease" means a disease:
   (1) caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and
   (2) treatable by the dietary restriction of one (1) or more amino acids.
As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-4
"Medical food"
Sec. 4. As used in this chapter, "medical food" means a formula that is:
   (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
   (2) formulated to be consumed or administered enterally under the direction of a physician.
As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-5
Coverage for medical food
Sec. 5. An accident and sickness insurance policy must provide coverage for medical food that is:
   (1) medically necessary; and
   (2) prescribed by a covered individual's treating physician for treatment of the covered individual's inherited metabolic disease.
As added by P.L.166-2003, SEC.2.

IC 27-8-24.1-6
Dollar limits, out-of-pocket expenses
Sec. 6. The coverage that must be provided under this chapter shall not be subject to dollar limits, coinsurance, or deductibles that are less favorable to a covered individual than the dollar limits, coinsurance, or deductibles that apply to coverage for:
   (1) prescription drugs generally under the accident and sickness insurance policy, if prescription drugs are covered under the accident and sickness insurance policy; or
   (2) physical illness generally under the accident and sickness insurance policy, if prescription drugs are not covered under the accident and sickness insurance policy.
As added by P.L.166-2003, SEC.2.
IC 27-8-24.2
Chapter 24.2. Coverage for Prosthetic Devices

IC 27-8-24.2-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.109-2008 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2008.
As added by P.L.220-2011, SEC.450.

IC 27-8-24.2-1
"Insured"
Sec. 1. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

IC 27-8-24.2-2
"Orthotic device"
Sec. 2. As used in this chapter, "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

IC 27-8-24.2-3
"Policy of accident and sickness insurance"
Sec. 3. (a) As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.
(b) The term does not include the following:
   (1) Accident only, credit, dental, vision, Medicare, 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 limited benefit health insurance policy.
   (6) A short term insurance plan that:
      (A) may not be renewed; and
      (B) has a duration of not more than six (6) months.
   (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
   (8) Worker's compensation or similar insurance.
   (9) A student health insurance policy.

IC 27-8-24.2-4
"Prosthetic device"
Sec. 4. As used in this chapter, "prosthetic device" means an artificial leg or arm.
IC 27-8-24.2-5
Coverage required
Sec. 5. A policy of accident and sickness insurance must provide coverage for orthotic devices and prosthetic devices, including repairs or replacements, that:
(1) are provided or performed by a person that is:
   (A) accredited as required under 42 U.S.C. 1395m(a)(20); or
   (B) a qualified practitioner (as defined in 42 U.S.C. 1395m(h)(1)(F)(iii));
(2) are determined by the insured's physician to be medically necessary to restore or maintain the insured's ability to perform activities of daily living or essential job related activities; and
(3) are not solely for comfort or convenience.

IC 27-8-24.2-6
Coverage and reimbursement
Sec. 6. The:
(1) coverage required under section 5 of this chapter must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program (42 U.S.C. 1395 et seq.); and
(2) reimbursement under the coverage required under section 5 of this chapter must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.
This section does not require a deductible under a policy of accident and sickness insurance to be equal to a deductible under the federal Medicare program.

IC 27-8-24.2-7
Comparison to other benefits
Sec. 7. Except as provided in sections 8 and 9 of this chapter, the coverage required under section 5 of this chapter:
(1) may be subject to; and
(2) may not be more restrictive than;
the provisions that apply to other benefits under the policy of accident and sickness insurance.

IC 27-8-24.2-8
Continued medical necessity review
Sec. 8. The coverage required under section 5 of this chapter may be subject to utilization review, including periodic review, of the continued medical necessity of the benefit.

IC 27-8-24.2-9
**Lifetime maximum coverage limitation**
Sec. 9. Any lifetime maximum coverage limitation that applies to prosthetic devices and orthotic devices:
   (1) must not be included in; and
   (2) must be equal to;
the lifetime maximum coverage limitation that applies to all other items and services generally under the policy of accident and sickness insurance.
*As added by P.L.109-2008, SEC.2.*

**IC 27-8-24.2-10**
**Deductible, copayment, or coinsurance requirements**
Sec. 10. For purposes of this section, "items and services" does not include preventive services for which coverage is provided under a high deductible health plan (as defined in 26 U.S.C. 220(c)(2) or 26 U.S.C. 223(c)(2)). The coverage required under section 5 of this chapter may not be subject to a deductible, copayment, or coinsurance provision that is less favorable to an insured than the deductible, copayment, or coinsurance provisions that apply to other items and services generally under the policy of accident and sickness insurance.
*As added by P.L.109-2008, SEC.2.*
IC 27-8-24.3  
Chapter 24.3. Insurance and Health Plan Coverage for Victims of Abuse

IC 27-8-24.3-0.1  
Application of chapter  
Sec. 0.1. The addition of this chapter by P.L.188-1996 applies only to an insurance policy or a health plan issued, renewed, or entered into after June 30, 1996.  

IC 27-8-24.3-1  
Applicability of chapter  
Sec. 1. This chapter applies to every:  
(1) policy of accident and sickness insurance (as described in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, a blanket basis, or under a preferred provider plan (as defined in IC 27-8-11-1);  
(2) group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services; and  
(3) policy of life insurance or disability insurance described under Class 1 of IC 27-1-5-1.  
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-2  
"Abuse" defined  
Sec. 2. As used in this chapter, "abuse" refers to the occurrence of one (1) or more of the following acts between family members or current or former household members:  
(1) Attempting to cause or intentionally, knowingly, or recklessly causing bodily injury to, physical harm to, sexual assault on, involuntary sexual intercourse with, or rape of another individual.  
(2) Knowingly engaging in a course of conduct or repeatedly committing acts, including stalking (as defined in IC 35-45-10-1) or impermissible contact (as defined in IC 35-45-10-3), under circumstances that place the individual toward whom such acts are directed in reasonable fear of bodily injury or physical harm.  
(3) Subjecting another individual to false imprisonment.  
(4) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property in order to intimidate or attempt to control the behavior of another individual.  
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-3  
"Individual" defined  
Sec. 3. As used in this chapter, "individual" means a natural person whether adult or minor.
IC 27-8-24.3-4
"An insurance policy or a health plan" defined
Sec. 4. As used in this chapter, "an insurance policy or a health plan" refers to an insurance policy or a health maintenance organization contract described in section 1 of this chapter.

IC 27-8-24.3-5
"Insurer" defined
Sec. 5. As used in this chapter, "insurer" means a company, a firm, a partnership, an association, an order, a society, or a system:
(1) making any of the kinds of insurance; or
(2) entering into any of the kinds of contracts; described in section 1 of this chapter.

IC 27-8-24.3-6
Prohibited acts by insurer
Sec. 6. Except as provided in sections 7 and 8 of this chapter, an insurer may not do any of the following:
(1) Deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy or a health plan because the individual:
   (A) has been, is, or has the potential to be a victim of abuse; or
   (B) seeks, has sought, or should have sought protection from abuse, shelter from abuse, or medical or psychological treatment for abuse.
(2) Add any surcharge or rating factor to a premium of an insurance policy or a health plan because an individual:
   (A) has a history of being; or
   (B) is; or
   (C) has the potential to be; a victim of abuse.
(3) Exclude or limit coverage for losses or deny a claim incurred by a person covered by an insurance policy or a health plan as a result of abuse or the potential for abuse.
(4) Designate that if an individual:
   (A) has a history of being a victim of abuse; or
   (B) is a victim of abuse; the abuse is a preexisting condition that causes coverage to be denied for a specified period.
(5) Ask an individual covered by or applying for an insurance policy or a health plan if the individual:
   (A) is, has been, or may be a victim of abuse; or
   (B) seeks, has sought, or should have sought protection from abuse, shelter from abuse, or medical or psychological
treatment for abuse.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-7
Insurer may adjust premiums
Sec. 7. This chapter does not prohibit an insurer from adjusting premiums of an individual applying for or covered by an insurance policy described in Class 1(a) of IC 27-1-5-1 on the basis that the individual has a physical or mental condition or medical claims history.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-8
Underwriting or rating risk on basis of physical or mental condition caused by abuse
Sec. 8. This chapter does not prohibit an insurer from inquiring about, underwriting, or rating a risk on the basis of a physical or mental condition, even if that condition has been caused by abuse if:
(1) the insurer routinely underwrites or charges a different rate for that condition in the same manner with respect to all individuals who apply for or are covered by an insurance policy or a health plan regardless of whether the individual has been the victim of abuse;
(2) the individual's status as being, having been, or having the potential to be the subject of abuse is not considered to be a physical or mental condition;
(3) the insurer does not:
   (A) refuse to insure or refuse to contract with;
   (B) refuse to continue to insure or refuse to continue to contract with;
   (C) limit the amount, extent, or coverage available; or
   (D) charge a different rate for the same coverage; solely because of a physical or mental condition, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actuarial or reasonably anticipated experience; and
(4) the underwriting or rating is not used to evade the intent of this chapter.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-9
Violations
Sec. 9. A violation of this chapter is an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4.
As added by P.L.188-1996, SEC.2.

IC 27-8-24.3-10
Immunity from liability
Sec. 10. An insurer is immune from civil and criminal liability for any damages caused as a result of the insurer's compliance with this
chapter.
As added by P.L.188-1996, SEC.2.
IC 27-8-24.7
Chapter 24.7. Referrals to Women's Health Care Providers

IC 27-8-24.7-1
"Health insurance policy" defined
Sec. 1. As used in this chapter, "health insurance policy" means any individual or group accident and sickness policy, contract, subscriber agreement, rider, endorsement, or any contract providing for the delivery of health care benefits, delivered or issued for delivery in Indiana after June 30, 1996, by any of the following:
   (1) An insurer.
   (2) A fraternal benefit society.
   (3) A nonprofit corporation.
   (4) A health maintenance organization (as defined in IC 27-13-1-19).
   (5) A preferred provider arrangement under IC 27-8-11.

IC 27-8-24.7-2
"Health insurer" defined
Sec. 2. As used in this chapter, "health insurer" means an entity referred to in section 1 of this chapter that issues, delivers, or renews a health insurance policy.

IC 27-8-24.7-3
"Insured" defined
Sec. 3. As used in this chapter, "insured" means an individual who is entitled to the benefits provided by a health insurance policy. The term includes the following:
   (1) A policyholder of an individual health insurance policy.
   (2) A member of the group covered by a group health insurance policy.
   (3) A female who is entitled to coverage under a health insurance policy as a spouse or dependent of an individual referred to in subdivision (1) or (2).

IC 27-8-24.7-4
"Women's health care provider" defined
Sec. 4. As used in this chapter, "women's health care provider" means a physician licensed under IC 25-22.5 who specializes in the provision of obstetric or gynecological services.

IC 27-8-24.7-5
Designation of women's health care provider as primary care provider
Sec. 5. Under a health insurance policy that is issued, delivered, issued for delivery, or renewed in Indiana, an organization or
arrangement described in section 1(1) through 1(5) of this chapter may not refuse to designate a women's health care provider as an insured's primary care provider if the women's health care provider meets the terms and conditions for participation established by an organization or arrangement described in section 1(1) through 1(5) of this chapter under an insurance policy as a primary care physician solely because the individual physician specializes in the provision of obstetric or gynecological services.

IC 27-8-25
Chapter 25. Coverage for Care Related to Clinical Trials

IC 27-8-25-1
"Care method"
Sec. 1. As used in this chapter, "care method" means the use of a particular drug or device in a particular manner.

IC 27-8-25-2
"Clinical trial"
Sec. 2. As used in this chapter, "clinical trial" means a Phase I, II, III, or IV research study:
(1) that is conducted:
   (A) using a particular care method to prevent, diagnose, or treat a cancer for which:
      (i) there is no clearly superior, noninvestigational alternative care method; and
      (ii) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;
   (B) in a facility where personnel providing the care method to be followed in the research study have:
      (i) received training in providing the care method;
      (ii) expertise in providing the type of care required for the research study; and
      (iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and
   (C) to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and
(2) that is approved or funded by one (1) of the following:
   (A) A National Institutes of Health institute.
   (B) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.
   (C) The federal Food and Drug Administration.
   (D) The United States Department of Veterans Affairs.
   (E) The United States Department of Defense.
   (F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.
   (G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
"Contracted provider"
Sec. 3. As used in this chapter, "contracted provider" means a health care provider that has entered into an agreement under IC 27-8-11-3 with an insurer that issues a policy of accident and sickness insurance.

IC 27-8-25-4 "Covered individual"
Sec. 4. As used in this chapter, "covered individual" means an individual entitled to coverage under a policy of accident and sickness insurance.

IC 27-8-25-5 "Noncontracted provider"
Sec. 5. As used in this chapter, "noncontracted provider" means a health care provider that has not entered into an agreement to serve as a contracted provider.

IC 27-8-25-6 "Policy of accident and sickness insurance"
Sec. 6. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

IC 27-8-25-7 "Routine care cost"
Sec. 7. As used in this chapter, "routine care cost" means the cost of medically necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:

(1) The health care service, item, or investigational drug that is the subject of the clinical trial.
(2) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
(3) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
(4) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
(5) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.
(6) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(7) A service, item, or drug that is eligible for reimbursement from a source other than a covered individual's policy of accident and sickness insurance, including the sponsor of the clinical trial.


IC 27-8-25-8

Coverage for routine care costs

Sec. 8. (a) A policy of accident and sickness insurance must provide coverage for routine care costs that are incurred in the course of a clinical trial if the policy of accident and sickness insurance would provide coverage for the same routine care costs not incurred in a clinical trial.

(b) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the policy of accident and sickness insurance, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by contracted providers and noncontracted providers.

(c) This section does not do any of the following:

(1) Require an insurer that issues a policy of accident and sickness insurance to provide coverage for clinical trial services rendered by a contracted provider.

(2) Prohibit an insurer that issues a policy of accident and sickness insurance from providing coverage for clinical trial services rendered by a contracted provider.

(3) Require reimbursement under a policy of accident and sickness insurance for services that are rendered in a clinical trial by a noncontracted provider at the same rate of reimbursement that would apply to the same services rendered by a contracted provider.


IC 27-8-25-9

No cause of action created by chapter

Sec. 9. This chapter does not create a cause of action against a person for any harm to a covered individual resulting from a clinical trial.

IC 27-8-26
Chapter 26. Genetic Screening or Testing

IC 27-8-26-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.150-1997 applies to all applications and policies for accident and sickness insurance delivered, issued for delivery, renewed, or executed after December 31, 1997.
As added by P.L.220-2011, SEC.452.

IC 27-8-26-1
Applicability of chapter
Sec. 1. (a) This chapter applies to the following:
1. Every policy of accident and sickness insurance (as defined in IC 27-8-5-1), whether written on an individual basis, a group basis, a franchise basis, or a blanket basis that is issued, delivered, or renewed in Indiana.
2. Every group contract (as defined in IC 27-13-1-16) or individual contract (as defined in IC 27-13-1-21) through which a health maintenance organization furnishes health care services that is delivered, executed, or renewed in Indiana.
3. Every health care plan of a state or local governmental entity that provides coverage for health care services on a self-insurance basis in Indiana.
4. Every employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.
(b) This chapter does not apply to the following:
1. Accident-only insurance, credit insurance, or disability income insurance.
2. Coverage issued as a supplement to liability insurance.
3. Worker's compensation or similar insurance.
4. Automobile medical payment insurance.
5. Life insurance.

IC 27-8-26-2
"Genetic screening or testing" defined
Sec. 2. (a) As used in this chapter, "genetic screening or testing" means a laboratory test:
1. of an individual's genes or chromosomes for abnormalities, defects, or deficiencies, including changes in the number, structure, or integrity of an individual's chromosomes or carrier status, that:
   A. are linked to physical or mental disorders or impairments;
   B. indicate a susceptibility to illness, disease, or other disorders, whether physical or mental; or
   C. demonstrate genetic or chromosomal damage due to environmental factors; and
that is a direct test for abnormalities, defects, or deficiencies in an individual's genes or chromosomes.
(b) The term does not include the detection of a genetic disorder through the manifestation of the genetic disorder.


**IC 27-8-26-3**
"Health care services coverage" defined
Sec. 3. As used in this chapter, "health care services coverage" refers to an insurance policy, a health maintenance organization contract, or a governmental health care plan described in section 1 of this chapter.


**IC 27-8-26-4**
"Insurer" defined
Sec. 4. As used in this chapter, "insurer" means a company, a firm, a partnership, an entity, an association, an order, a society, or a system:
(1) making any of the kinds of insurance;
(2) entering into any of the kinds of contracts; or
(3) providing any of the coverage;
described in section 1 of this chapter.


**IC 27-8-26-5**
Determination of eligibility for health care services coverage by insurer; prohibitions
Sec. 5. In processing an application for health care services coverage or in determining insurability for health care services coverage, an insurer may not do any of the following:
(1) Require an individual or any member of an individual's family seeking health care services coverage to submit to genetic screening or testing.
(2) Consider any information obtained from genetic screening or testing in a manner adverse to:
   (A) an applicant or a member of an applicant's family for;
   (B) an individual or a member of an individual's family covered by;
health care services coverage.
(3) Inquire, directly or indirectly, into the results of genetic screening or testing, or use such information to cancel, refuse to issue or renew, or limit benefits under health care services coverage.
(4) Make a decision adverse to an applicant or a member of an applicant's family based on entries related to the results of genetic testing or screening in medical records or other reports of genetic screening or testing.

IC 27-8-26-6  
Questions by insurer regarding genetic screening or testing results prohibited  
Sec. 6. In developing and asking questions regarding the medical history of an applicant for health care services coverage, an insurer may not ask:
(1) for the results of; or
(2) questions designed to ascertain the results of; genetic screening or testing.  

IC 27-8-26-7  
Refusal of health care services coverage based on genetic screening or testing results prohibited  
Sec. 7. An insurer may not cancel, refuse to issue, refuse to renew, or refuse to enter into a contract for health care services coverage based on the results of genetic screening or testing.  

IC 27-8-26-8  
Limitation of benefits or establishment of premiums based on genetic screening or testing results prohibited  
Sec. 8. An insurer may not deliver, issue for delivery, renew, or execute a contract for health care services coverage in Indiana that:
(1) limits benefits; or
(2) establishes premiums; based on the results of genetic screening or testing.  

IC 27-8-26-9  
Consideration of genetic screening or testing results by insurer  
Sec. 9. An insurer may consider the results of genetic screening or testing if:
(1) the results are voluntarily submitted by:
(A) an applicant for; or
(B) an individual seeking renewal of; health care services coverage; and
(2) the results are favorable to the applicant or the individual.  

IC 27-8-26-10  
Enforcement of chapter; rules  
Sec. 10. (a) The commissioner shall enforce this chapter.  
(b) The commissioner may adopt rules under IC 4-22-2 to carry out this chapter.  

IC 27-8-26-11  
Violation unfair and deceptive act or practice  
Sec. 11. A violation of this chapter is an unfair and deceptive act
or practice in the business of insurance under IC 27-4-1-4.

IC 27-8-27
Chapter 27. Coverage for Services to Infants and Toddlers With Disabilities

IC 27-8-27-1
"Early intervention services" defined
Sec. 1. For purposes of this chapter, "early intervention services" means services provided to a first steps child under IC 12-12.7-2 and 20 U.S.C. 1432(4).

IC 27-8-27-2
"First steps child" defined
Sec. 2. For purposes of this chapter, "first steps child" means an infant or toddler from birth through two (2) years of age who is enrolled in the Indiana first steps program and is an insured.

IC 27-8-27-3
"First steps program" defined
Sec. 3. As used in this chapter, "first steps program" means the program established under IC 12-12.7-2 and 20 U.S.C. 1431 et seq. to meet the needs of:
(1) children who are eligible for early intervention services; and
(2) their families.
The term includes the coordination of all available federal, state, local, and private resources available to provide early intervention services within Indiana.

IC 27-8-27-4
"Health insurance plan" defined
Sec. 4. (a) For purposes of this chapter, "health insurance plan" means any:
(1) hospital or medical expense incurred policy or certificate;
(2) hospital or medical service plan contract; or
(3) health maintenance organization subscriber contract;
provided to an insured.
(b) The term does not include the following:
(1) Accident-only, credit, dental, Medicare supplement, long term care, or disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Worker's compensation or similar insurance.
(4) Automobile medical payment insurance.
(5) A specified disease policy issued as an individual policy.
(6) A limited benefit health insurance plan issued as an individual 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 a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.


IC 27-8-27-5
"Insured" defined
Sec. 5. As used in this chapter, "insured" means an individual covered by a health insurance plan.

IC 27-8-27-6
Reimbursement of first steps program for early intervention services payments
Sec. 6. A health insurance plan that provides coverage for early intervention services shall reimburse the first steps program a monthly fee established by the division of disability and rehabilitative services. The monthly fee shall be provided instead of claims processing of individual claims.

IC 27-8-27-7
Repealed
(Repealed by P.L.246-2005, SEC.231.)

IC 27-8-27-8
Reimbursement not to be applied to lifetime coverage limit
Sec. 8. The reimbursement required under section 6 of this chapter may not be applied to any annual or aggregate lifetime limit on the first steps child's coverage under the health insurance plan.

IC 27-8-27-9
Payment of deductibles, copayments, or other expenses
Sec. 9. The first steps program may pay required deductibles, copayments, or other out-of-pocket expenses for a first steps child directly to a provider. An insurer (as defined in IC 27-8-14.5-3) shall apply any payments made by the first steps program to the health insurance plan's deductibles, copayments, or other out-of-pocket expenses according to the terms and conditions of the health insurance plan.
IC 27-8-28
Chapter 28. Internal Grievance Procedures

IC 27-8-28-1
"Accident and sickness insurance policy"
Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.
(b) 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 issued as an individual policy.
   (5) A limited benefit health insurance policy issued as an individual policy.
   (6) A short term insurance plan that:
       (A) may not be renewed; and
       (B) has a duration of not more than six (6) months.
   (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.
   (8) Worker's compensation or similar insurance.

IC 27-8-28-2
"Commissioner"
Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

IC 27-8-28-3
"Covered individual"
Sec. 3. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

IC 27-8-28-4
"Department"
Sec. 4. As used in this chapter, "department" refers to the department of insurance.

IC 27-8-28-5
"External grievance"
Sec. 5. As used in this chapter, "external grievance" means the independent review under IC 27-8-29 of a grievance filed under this
chapter.

IC 27-8-28-6
"Grievance"
Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(1) a determination that a service or proposed service is not appropriate or medically necessary;
(2) a determination that a service or proposed service is experimental or investigational;
(3) the availability of participating providers;
(4) the handling or payment of claims for health care services;
(5) matters pertaining to the contractual relationship between:
   (A) a covered individual and an insurer; or
   (B) a group policyholder and an insurer; or
(6) an insurer's decision to rescind an accident and sickness insurance policy;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

IC 27-8-28-7
"Grievance procedure"
Sec. 7. As used in this chapter, "grievance procedure" means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

IC 27-8-28-8
"Insured"
Sec. 8. As used in this chapter, "insured" means:

(1) an individual whose employment status or other status except family dependency is the basis for coverage under a group accident and sickness insurance policy; or
(2) in the case of an individual accident and sickness insurance policy, the individual in whose name the policy is issued.

IC 27-8-28-9
"Insurer"
Sec. 9. As used in this chapter, "insurer" means any person who delivers or issues for delivery an accident and sickness insurance policy or certificate in Indiana.

IC 27-8-28-10
Grievance procedure to comply with chapter requirements
Sec. 10. An insurer shall establish and maintain a grievance procedure that complies with the requirements of this chapter for the resolution of grievances initiated by a covered individual.

IC 27-8-28-11
Commissioner may examine procedure
Sec. 11. The commissioner may examine the grievance procedure of any insurer.

IC 27-8-28-12
Grievance records
Sec. 12. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer's grievance procedure by the commissioner.

IC 27-8-28-13
Insurer to provide notice to insured
Sec. 13. (a) An insurer shall provide timely, adequate, and appropriate notice to each insured of:
(1) the grievance procedure required under this chapter;
(2) the external grievance procedure required under IC 27-8-29;
(3) information on how to file:
   (A) a grievance under this chapter; and
   (B) a request for an external grievance review under IC 27-8-29; and
(4) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances.
(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

IC 27-8-28-14
Filing grievance; toll free number
Sec. 14. (a) A covered individual may file a grievance orally or in writing.
(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:
(1) be staffed by a qualified representative of the insurer;
(2) be available for at least forty (40) hours per week during normal business hours; and
(3) accept grievances in the languages of the major population groups served by the insurer.
(c) A grievance is considered to be filed on the first date it is
received, either by telephone or in writing.  

**IC 27-8-28-15**  
Assistance in filing grievance; designation of representative  
Sec. 15. (a) An insurer shall establish procedures to assist covered individuals in filing grievances.  
(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this chapter.  

**IC 27-8-28-16**  
Policies and procedures for timely resolution of grievances  
Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:  
(1) An acknowledgment of the grievance, given orally or in writing, to the covered individual within five (5) business days after receipt of the grievance.  
(2) Documentation of the substance of the grievance and any actions taken.  
(3) An investigation of the substance of the grievance, including any aspects involving clinical care.  
(4) Notification to the covered individual of the disposition of the grievance and the right to appeal.  
(5) Standards for timeliness in:  
(A) responding to grievances; and  
(B) providing notice to covered individuals of:  
(i) the disposition of the grievance; and  
(ii) the right to appeal;  
that accommodate the clinical urgency of the situation.  
(b) An insurer shall appoint at least one (1) individual to resolve a grievance.  
(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the insurer receives all information reasonably necessary to complete the review. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall:  
(1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and  
(2) issue a written decision regarding the grievance within an additional ten (10) business days.  
(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:  
(1) A statement of the decision reached by the insurer.  
(2) A statement of the reasons, policies, and procedures that are
IC 27-8-28-17
Policies and procedures for timely resolution of appeals of grievance decisions; filing of report for violation

Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

1. Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.
2. Documentation of the substance of the appeal and the actions taken.
3. Investigation of the substance of the appeal, including any aspects of clinical care involved.
4. Notification to the covered individual:
   A. of the disposition of an appeal; and
   B. that the covered individual may have the right to further remedies allowed by law.
5. Standards for timeliness in:
   A. responding to an appeal; and
   B. providing notice to covered individuals of:
      i. the disposition of an appeal; and
      ii. the right to initiate an external grievance review under IC 27-8-29;

that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

1. have knowledge of the medical condition, procedure, or treatment at issue;
2. are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
3. are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and
4. do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:
(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and
(2) not later than forty-five (45) days after the appeal is filed.
An insurer that violates this subsection commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4.

(d) If an insurer violates subsection (c), the insurer shall file a report with the department during the quarter in which the violation occurred concerning the insurer's compliance with subsection (c). The report must include the following:
(1) The number of appealed grievance decisions that were not resolved as required under subsection (c).
(2) The reason each appeal described in subdivision (1) was not resolved.

(e) An insurer shall allow a covered individual the opportunity to:
(1) appear in person before; or
(2) if unable to appear in person, otherwise appropriately communicate with;
the panel appointed under subsection (b).

(f) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:
(1) A statement of the decision reached by the insurer.
(2) A statement of the reasons, policies, and procedures that are the basis of the decision.
(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.
(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.


IC 27-8-28-18
Insurer prohibited from taking action
Sec. 18. An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this chapter.

IC 27-8-28-19
Filing description of grievance procedure
Sec. 19. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:
(1) the total number of grievances handled through the procedure during the preceding calendar year;
(2) a compilation of the causes underlying those grievances; and
(3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:
(1) make the information required to be filed under this section available to the public; and
(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.


IC 27-8-28-20
Adoption of rules
Sec. 20. The department may adopt rules under IC 4-22-2 to implement this chapter.

IC 27-8-29
Chapter 29. External Review of Grievances

IC 27-8-29-1
"Accident and sickness insurance policy" defined
Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-28-1.

IC 27-8-29-2
"Appeal" defined
Sec. 2. As used in this chapter, "appeal" means the procedure described in IC 27-8-28-17.

IC 27-8-29-3
"Commissioner" defined
Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

IC 27-8-29-4
"Covered individual" defined
Sec. 4. As used in this chapter, "covered individual" has the meaning set forth in IC 27-8-28-3.

IC 27-8-29-5
"Department" defined
Sec. 5. As used in this chapter, "department" refers to the department of insurance.

IC 27-8-29-6
"External grievance" defined
Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:
(1) grievance filed under IC 27-8-28; or
(2) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

IC 27-8-29-7
"Grievance" defined
Sec. 7. As used in this chapter, "grievance" has the meaning set forth in IC 27-8-28-6.
IC 27-8-29-8
"Grievance procedure" defined
Sec. 8. As used in this chapter, "grievance procedure" has the meaning set forth in IC 27-8-28-7.

IC 27-8-29-9
"Health care provider" defined
Sec. 9. As used in this chapter, "health care provider" means a person:
(1) that provides physician services (as defined in IC 12-15-11-1(a)); or
(2) who is licensed under IC 25-33.

IC 27-8-29-10
"Insured" defined
Sec. 10. As used in this chapter, "insured" has the meaning set forth in IC 27-8-28-8.

IC 27-8-29-11
"Insurer" defined
Sec. 11. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-28-9.

IC 27-8-29-12
Insurer to establish external grievance procedures
Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding the following:
(1) The following determinations made by the insurer or an agent of the insurer regarding a service proposed by the treating health care provider:
   (A) An adverse determination of appropriateness.
   (B) An adverse determination of medical necessity.
   (C) A determination that a proposed service is experimental or investigational.
   (D) A denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).
(2) The insurer's decision to rescind an accident and sickness insurance policy.

IC 27-8-29-13
Requirements for external grievance procedure; independent
review organizations

Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual, or a covered individual's representative, to file a written request with the insurer for an external grievance review of the insurer's
   (A) appeal resolution under IC 27-8-28-17 or
   (B) denial of coverage based on a waiver described in IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed); not more than one hundred twenty (120) days after the covered individual is notified of the resolution; and
(2) provide for:
   (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:
      (i) life or health; or
      (ii) ability to reach and maintain maximum function; or
   (B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and
(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.
(2) Any officer, director, or management employee of the insurer.
(3) The health care provider or the health care provider's medical group that is proposing the service.
(4) The facility at which the service would be provided.
(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.
(6) The covered individual requesting the external grievance review.
However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.


IC 27-8-29-14
Rights of individuals who file grievances
Sec. 14. (a) A covered individual who files an external grievance under this chapter:
   (1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;
   (2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
   (3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and
   (4) shall cooperate with the independent review organization by:
       (A) providing any requested medical information; or
       (B) authorizing the release of necessary medical information.
   (b) An insurer shall cooperate with an independent review organization selected under section 13(b) of this chapter by promptly providing any information requested by the independent review organization.


IC 27-8-29-15
Independent review organizations; determinations
Sec. 15. (a) An independent review organization shall:
   (1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours after the external grievance is filed; or
   (2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the external grievance is filed;
make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.
(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and
(2) the terms of the covered individual's accident and sickness insurance policy.

(c) In an external grievance described in section 12(1)(D) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5(e) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and
(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.


IC 27-8-29-15.5
Information from independent review organization
Sec. 15.5. Upon the request of a covered individual who is notified under section 15(d) of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the covered individual all information reasonably necessary to enable the covered individual to understand the:

(1) effect of the determination on the covered individual; and
(2) manner in which the insurer may be expected to respond to the determination.

As added by P.L.173-2007, SEC.42.

IC 27-8-29-16
Binding determinations
Sec. 16. A determination made under section 15 of this chapter is binding on the insurer.


IC 27-8-29-17
Reconsideration of resolution by insurer
Sec. 17. (a) If, at any time during an external review performed under this chapter, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered
individual's appeal of a grievance decision under IC 27-8-28-17 and that was not considered by the insurer under IC 27-8-28:

(1) the insurer may reconsider the resolution under IC 27-8-28-17; and

(2) if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration under subsection (b) is completed.

(b) An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution under IC 27-8-28-17 based on the information and notify the covered individual of the insurer's decision:

(1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:
   (A) life or health; or
   (B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted, for a reconsideration not described in subdivision (1).

(c) If the decision reached under subsection (b) is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

(d) If an insurer to which information is submitted under subsection (a) chooses not to reconsider the insurer's resolution under IC 27-8-28-17, the insurer shall forward the submitted information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.


IC 27-8-29-18
Applicability of chapter
Sec. 18. This chapter does not add to or otherwise change the terms of coverage included in a policy, certificate, or contract under which a covered individual receives health care benefits under IC 27-8.


IC 27-8-29-19
Annual certifications of independent review organizations
Sec. 19. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization must meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent
review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which a covered individual's proposed service would be provided;
(B) must be knowledgeable about a proposed service through actual clinical experience;
(C) must hold an unlimited license to practice in a state of the United States; and
(D) must not have any history of disciplinary actions or sanctions, including:
   (i) loss of staff privileges; or
   (ii) restriction on participation;
taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure:
(A) the timeliness and quality of reviews;
(B) the qualifications and independence of medical review professionals;
(C) the confidentiality of medical records and other review materials; and
(D) the satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(3) The independent review organization must file with the department the following information on or before March 1 of each year:
(A) The number and percentage of determinations made in favor of covered individuals.
(B) The number and percentage of determinations made in favor of insurers.
(C) The average time to process a determination.
(D) The number of external grievance reviews terminated due to reconsideration of the insurer before a determination was made.
(E) Any other information required by the department.

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(4) The independent review organization must retain all records related to an external grievance review for at least three (3) years after a determination is made under section 15 of this chapter.

(5) Any additional requirements established by the department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.
(2) An insurer, a health maintenance organization, or a health
plan association, or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to insurers a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual covered individuals.


IC 27-8-29-20
Documents of review organizations

Sec. 20. Except as provided in section 19(g) of this chapter, documents and other information created or received by the independent review organization or the medical review professional in connection with an external grievance review under this chapter:

(1) are not public records;
(2) may not be disclosed under IC 5-14-3; and
(3) must be treated in accordance with confidentiality requirements of state and federal law.


IC 27-8-29-21
Filing description of grievance procedure

Sec. 21. (a) An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

(1) the total number of external grievances handled through the procedure during the preceding calendar year;
(2) a compilation of the causes underlying those grievances; and
(3) a summary of the final disposition of those grievances; for each independent review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and
(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

IC 27-8-29-22
Immunity from civil liability; work product or determination
   Sec. 22. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.
   (b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or persuasion concerning any material issue of fact or law.

IC 27-8-29-23
Medicare
   Sec. 23. If a covered individual has the right to an external review of a grievance under Medicare, the covered individual may not request an external review of the same grievance under this chapter.

IC 27-8-29-24
Rules
   Sec. 24. The department may adopt rules under IC 4-22-2 to implement this chapter.
IC 27-8-30
Chapter 30. Specific Accident and Sickness Insurance Reporting Requirements

IC 27-8-30-1
"Accident and sickness insurance policy" defined
Sec. 1. As used in this chapter, "accident and sickness insurance policy" means a policy that:
(1) provides the kinds of coverage described in Class 1(b) or Class 2(a) of IC 27-1-5-1; and
(2) includes a prescription drug benefit.

IC 27-8-30-2
"Covered individual" defined
Sec. 2. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

IC 27-8-30-3
Allowing an insurer to report the number of covered children who are prescribed a stimulant medication for the treatment of certain disorders
Sec. 3. An insurer that issues an accident and sickness insurance policy may report to the drug utilization review board established by IC 12-15-35-19 the number of covered individuals who are:
(1) less than eighteen (18) years of age; and
(2) prescribed a stimulant medication approved by the federal Food and Drug Administration for the treatment of attention deficit disorder or attention deficit hyperactivity disorder.
IC 27-8-31
Chapter 31. Interstate Insurance Product Regulation Compact

IC 27-8-31-1
Purpose
Sec. 1. The purposes of this compact are, through means of joint
and cooperative action among the compacting states, to:
(1) promote and protect the interest of consumers of individual
and group annuity, life insurance, disability income, and long
term care insurance products;
(2) develop uniform standards for insurance products covered
under the compact;
(3) establish a central clearinghouse to receive and provide
prompt review of insurance products covered under the compact
and, in certain cases, advertisements related thereto, submitted
by insurers authorized to do business in one (1) or more
compacting states;
(4) give appropriate regulatory approval to product filings and
advertisements satisfying the applicable uniform standard;
(5) improve coordination of regulatory resources and expertise
between state insurance departments regarding the setting of
uniform standards and review of insurance products covered
under the compact;
(6) create the interstate insurance product regulation
commission; and
(7) perform these and any other related functions as may be
consistent with the state regulation of the business of insurance.

IC 27-8-31-2
Definitions
Sec. 2. (a) The definitions in this section apply throughout this
chapter.
(b) "Advertisement" means material designed to create public
interest in a product or induce the public to purchase, increase,
modify, reinstate, borrow on, surrender, replace, or retain a policy, as
more specifically defined in the rules and operating procedures of the
commission.
(c) "Bylaws" means bylaws established by the commission for the
governance, direction, or control of the commission.
(d) "Commission" refers to the interstate insurance product
regulation commission established by section 3 of this chapter.
(e) "Commissioner" means the chief insurance regulatory official
of a state, including a commissioner, a superintendent, a director, or
an administrator.
(f) "Compacting state" means a state that:
(1) has enacted this compact; and
(2) has not:
   (A) withdrawn as provided in section 15 of this chapter; or
   (B) been terminated as provided in section 16 of this chapter.
(g) "Domiciliary state" means the state in which an insurer is incorporated or organized, or the state of entry of an alien insurer.

(h) "Insurer" means an entity licensed by a state to issue contracts of insurance for the lines of insurance covered by this chapter.

(i) "Member" means the commissioner or the commissioner's designee.

(j) "NAIC" refers to the National Association of Insurance Commissioners.

(k) "Noncompacting state" means a state that is not a compacting state.

(l) "Operating procedures" mean procedures adopted by the commission to implement a rule, a uniform standard, or a provision of this compact.

(m) "Opt out" means any action by a compacting state to decline to adopt or participate in a promulgated uniform standard.

(n) "Product" means the form of a policy or contract, including an application, an endorsement, or a related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or a group annuity, life insurance, disability income, or long term care insurance product that an insurer is authorized to issue in Indiana or another compacting state.

(o) "Rule" means a statement of general or particular applicability and future effect adopted by the commission, including a uniform standard developed under section 8 of this chapter, that has the full force and effect of law in the compacting states and:

1. is designed to implement or interpret law or prescribe policy; or
2. describes the organization, procedure, or practice requirements of the commission.

(p) "State" means a state, district, or territory of the United States.

(q) "Third party filer" means an entity that submits a product filing to the commission on behalf of an insurer.

(r) "Uniform standard" means a standard adopted by the commission for a product line under section 8 of this chapter. The term includes all the product requirements. However:

1. each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product; and
2. the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the commission.


IC 27-8-31-3
Interstate insurance product regulation commission

Sec. 3. (a) The compacting states hereby establish a joint public agency known as the interstate insurance product regulation commission. Under section 4 of this chapter, the commission may:

1. develop uniform standards for product lines;
2. receive and provide prompt review of products filed with the
commission; and
(3) give approval to product filings satisfying applicable uniform standards.

However, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. This chapter does not prohibit an insurer from filing the insurer's product in a state where the insurer is licensed to conduct the business of insurance and any such filing is subject to the laws of the state where filed.

(b) The commission is a body corporate and politic, and an instrumentality of the compacting states.

(c) The commission is solely responsible for the commission's liabilities except as otherwise specifically provided in this compact.

(d) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court with jurisdiction where the principal office of the commission is located. 


IC 27-8-31-4 Commission powers
Sec. 4. The commission has the following powers:
(1) To adopt rules under section 8 of this chapter, which shall have the force and effect of law and are binding in the compacting states to the extent and in the manner provided in this compact.

(2) To exercise the commission's rulemaking authority and establish reasonable uniform standards for products covered under the compact and advertisement related to the products, which shall have the force and effect of law and are binding in the compacting states, but only for those products filed with the commission. However, a compacting state has the right to opt out of the uniform standard under section 8(d) of this chapter, to the extent and in the manner provided in this compact, and any uniform standard established by the commission for long term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the NAIC's long term care insurance model act and long term care insurance model regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the NAIC long term care insurance model act or long term care insurance model regulation adopted by the NAIC require amending the uniform standards established by the commission for long term care insurance products.

(3) To receive and review in an expeditious manner products filed with the commission and rate filings for disability income and long term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where the approval shall have the force and effect of law and is binding on the compacting states to the
extent and in the manner provided in the compact.
(4) To receive and review in an expeditious manner
advertisement relating to long term care insurance products for
which uniform standards have been adopted by the commission,
and give approval to all advertisement that satisfies the
applicable uniform standard. For any product covered under this
compact, other than long term care insurance products, the
commission has authority to require an insurer to submit all or
any part of the insurer's advertisement with respect to that
product for review or approval before use, if the commission
determines that the nature of the product is such that an
advertisement of the product could have the capacity or
tendency to mislead the public. The actions of the commission
as provided in this section shall have the force and effect of law
and are binding in the compacting states to the extent and in the
manner provided in the compact.
(5) To exercise the commission's rulemaking authority and
designate products and advertisement that may be subject to a
self-certification process without the need for prior approval by
the commission.
(6) To adopt operating procedures under section 8 of this
chapter, which shall have the force and effect of law and are
binding in the compacting states to the extent and in the manner
provided in this compact.
(7) To bring and prosecute legal proceedings or actions in the
commission's name as the commission, provided that the
standing of any state insurance department to sue or be sued
under applicable law shall not be affected.
(8) To issue subpoenas requiring the attendance and testimony
of witnesses and the production of evidence.
(9) To establish and maintain offices.
(10) To purchase and maintain insurance and bonds.
(11) To borrow, accept, or contract for services of personnel,
including employees of a compacting state.
(12) To hire employees, professionals, or specialists, elect or
appoint officers, and fix their compensation, define their duties,
give them appropriate authority to carry out the purposes of the
compact, determine their qualifications, and establish the
commission's personnel policies and programs relating to,
among other things, conflicts of interest, rates of compensation,
and qualifications of personnel.
(13) To accept any and all appropriate donations and grants of
money, equipment, supplies, materials, and services, and to
receive, use, and dispose of the same. At all times the
commission shall strive to avoid any appearance of impropriety.
(14) To lease, purchase, accept appropriate gifts or donations of,
or otherwise to own, hold, improve, or use any property, real,
personal, or mixed. At all times the commission shall strive to
avoid any appearance of impropriety.
(15) To sell, convey, mortgage, pledge, lease, exchange,
abandon, or otherwise dispose of any property, real, personal, or mixed.

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures.

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws.

(18) To provide for dispute resolution among compacting states.

(19) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact.

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments.

(21) To establish a budget and make expenditures.

(22) To borrow money.

(23) To appoint committees, including advisory committees, comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and any other interested persons as may be designated in the bylaws.

(24) To provide and receive information from and to cooperate with law enforcement agencies.

(25) To adopt and use a corporate seal.

(26) To perform any other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.


IC 27-8-31-5
Commission members; action; bylaws
Sec. 5. (a) Each compacting state shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity under applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state where the vacancy exists. Nothing in this section shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of the compacting state's commissioner.

(b) Each member is entitled to one (1) vote and is entitled to an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision in this chapter to the contrary, no action of the commission with respect to the promulgation of a uniform standard is effective unless two-thirds (2/3) of the members vote in favor of adoption.

(c) The commission shall, by a majority of the members, prescribe bylaws to govern the commission's conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including the following:
(1) Establishing the fiscal year of the commission.
(2) Providing reasonable procedures for appointing and electing members and holding meetings of the management committee.
(3) Providing reasonable standards and procedures:
   (A) for the establishment and meetings of other committees; and
   (B) governing any general or specific delegation of any authority or function of the commission.
(4) Providing reasonable procedures for calling and conducting meetings of the commission and ensuring reasonable advance notice of each meeting, including:
   (A) requiring a majority of commission members to attend a meeting;
   (B) providing for the right of citizens to attend the meetings with enumerated exceptions designed to:
      (i) protect the public interest;
      (ii) protect the privacy of individuals; and
      (iii) insure proprietary information, including trade secrets;
   (C) allowing a meeting in camera only after a majority of the members of the commission votes to close a meeting en toto or in part, with no proxy voting; and
   (D) providing for the commission, as soon as practicable after a vote to close a meeting as described in clause (C), to make public:
      (i) a copy of the vote to close the meeting revealing the vote of each member; and
      (ii) votes taken during the meeting.
(5) Establishing the titles, duties, authority, and reasonable procedures for the election of the officers of the commission.
(6) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission.
(7) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees.
(8) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and reserving of all the commission's debts and obligations.

(d) The commission shall publish bylaws in a convenient form and file a copy of the bylaws and amendments to the bylaws with the appropriate agency or officer in each compacting state.


IC 27-8-31-6
Management committee; legislative committee; liability

Sec. 6. (a) A management committee comprising not more than fourteen (14) members shall be established as follows:
(1) One (1) member from each of the six (6) compacting states with the largest premium volume for individual and group annuities, life, disability income, and long term care insurance products, determined from the records of the NAIC for the prior year.

(2) Four (4) members from those compacting states with at least two percent (2%) of the market based on the premium volume described in subdivision (1), other than the six (6) compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws.

(3) Four (4) members from those compacting states with less than two percent (2%) of the market, based on the premium volume described in subdivision (1), with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the bylaws.

(b) The management committee has the authority and duties as may be set forth in the bylaws, including the following:

(1) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission.

(2) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard. However, a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds (2/3) of the members of the management committee.

(3) Overseeing the offices of the commission.

(4) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations to advance the goals of the commission.

(c) The commission shall annually elect officers from the management committee, with each having the authority and duties as may be specified in the bylaws.

(d) The management committee may, subject to the approval of the commission, appoint or retain an executive director for the period, upon the terms and conditions and for the compensation as the commission considers appropriate. The executive director shall serve as secretary to the commission but may not be a member of the commission. The executive director shall hire and supervise any other staff as may be authorized by the commission.

(e) A legislative committee comprised of state legislators or state legislators' designees shall be established to monitor the operations of and make recommendations to the commission, including the management committee. However, the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Before the commission adopts any uniform standard, revision to the bylaws, annual budget, or other significant matter as may be
provided in the bylaws, the management committee shall consult with and report to the legislative committee. The commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry and the other of which shall comprise insurance industry representatives. The commission may establish additional advisory committees as the commission's bylaws may provide for the carrying out of the commission's functions.

(f) The commission shall maintain its corporate books and records in accordance with the bylaws.

(g) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, nothing in this subsection shall be construed to protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the person.

(h) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However:

(1) nothing in this subsection shall be construed to prohibit that person from retaining the person's own counsel; and
(2) this subsection applies only if the actual or alleged act, error, or omission did not result from the person's intentional or willful and wanton misconduct.

(i) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against the person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection applies only if the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.


IC 27-8-31-7
Commission action
Sec. 7. (a) The commission shall meet and take any actions that
are consistent with this compact and the bylaws.

(b) Each member of the commission is entitled to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least one (1) time during each calendar year. Additional meetings shall be held as set forth in the bylaws.


IC 27-8-31-8
Rules; uniform standards; opting out; judicial review

Sec. 8. (a) The commission shall adopt reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. However, if the commission exercises the commission's rulemaking authority in a manner that is beyond the scope of the purposes of this chapter or the powers granted in this chapter, the action by the commission is invalid and has no force and effect.

(b) Rules and operating procedures shall be made according to a rulemaking process that substantially conforms to the principles of the model state administrative procedure act of 1981, as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of the commission's intention to adopt the uniform standard. The commission, in adopting a uniform standard, shall fully consider all submitted materials and issue a concise explanation of the commission's decision.

(c) A uniform standard becomes effective ninety (90) days after the uniform standard's adoption by the commission or on a later date as the commission may determine. However, a compacting state may opt out of a uniform standard as provided in subsection (d). All other rules and operating procedures and amendments to the other rules and operating procedures become effective as of the date specified in each rule, operating procedure, or amendment.

(d) A compacting state may opt out of a uniform standard, either by legislation or by rule adopted by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by rule, the compacting state must:

(1) give written notice to the commission not later than ten (10) business days after the uniform standard is adopted or at the time the state becomes a compacting state; and
(2) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the
evidence, detailing the conditions in the state that warrant a
departure from the uniform standard and determining that the
uniform standard would not reasonably protect the citizens of
the state. The commissioner must balance, consider, and find
that the conditions in the state and needs of the citizens of the
state outweigh the following factors:

(A) The intent of the legislature to participate in, and the
benefits of, an interstate agreement to establish national
uniform consumer protections for the products subject to this
chapter.

(B) The presumption that a uniform standard adopted by the
commission provides reasonable protections to consumers of
the relevant product.

However, a compacting state may, at the time of the compacting
state's enactment of this compact, prospectively opt out of all uniform
standards involving long term care insurance products by expressly
providing for an opt out in the enacted compact, and the opt out shall
not be treated as a material variance in the offer or acceptance of any
state to participate in this compact. The opt out is effective at the time
of enactment of this compact by the compacting state and shall apply
to all existing uniform standards involving long term care insurance
products and those subsequently adopted.

(e) If a compacting state elects to opt out of a uniform standard,
the uniform standard remains applicable in the compacting state
electing to opt out until the time the opt out legislation is enacted or
the regulation opting out becomes effective. Once the opt out of a
uniform standard by a compacting state becomes effective as
provided under the laws of the state, the uniform standard shall have
no further force and effect in the state unless and until the legislation
or regulation implementing the opt out is repealed or otherwise
becomes ineffective under the laws of the state. If a compacting state
opts out of a uniform standard after the uniform standard has been
made effective in the state, the opt out shall have the same
prospective effect as provided under section 15 of this chapter for
withdrawals.

(f) If a compacting state has formally initiated the process of
opting out of a uniform standard by rule while the regulatory opt out
is pending, the compacting state may petition the commission, not
less than fifteen (15) days before the effective date of the uniform
standard, to stay the effectiveness of the uniform standard in the
compacting state. The commission may grant a stay if the
commission determines the regulatory opt out is being pursued in a
reasonable manner and there is a likelihood of success. If a stay is
granted or extended by the commission, the stay or extension may
postpone the effective date by not more than ninety (90) days, unless
the stay is extended by the commission. However, a stay may not be
permitted to remain in effect for more than one (1) year unless the
compacting state can show extraordinary circumstances that warrant
a continuance of the stay, including the existence of a legal challenge
that prevents the compacting state from opting out. A stay may be
terminated by the commission on notice that the rulemaking process has been terminated.

(g) Not later than thirty (30) days after a rule or operating procedure is adopted, any person may file a petition for judicial review of the rule or operating procedure. However, the filing of a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.


IC 27-8-31-9
Commission information and records; disclosure; confidentiality; compacting state compliance and oversight

Sec. 9. (a) The commission shall adopt rules establishing conditions and procedures for public inspection and copying of the commission's information and official records, except information and records involving the privacy of individuals and trade secrets of insurers. The commission may adopt additional rules under which the commission may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with these agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the commission. However, disclosure to the commission shall not be considered to waive or otherwise affect any confidentiality requirement, and, except as otherwise expressly provided in this chapter, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in the commission's possession. Confidential information of the commission remains confidential after the information is provided to any commissioner.

(c) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of the noncomplying compacting state's noncompliance with commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy the noncomplying compacting state's noncompliance within the time specified in the notice of noncompliance, the compacting state is considered to be in default as set forth in section 16 of this chapter.

(d) The commissioner of any state in which an insurer is
authorized to do business or is conducting the business of insurance shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following:

(1) With respect to the commissioner's market regulation of a product or an advertisement that is approved or certified to the commission, the content of the product or advertisement does not constitute a violation of the provisions, standards, or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

(2) Before a commissioner may bring an action for violation of a provision, standard, or requirement of the compact related to the content of an advertisement not approved or certified to the commission, the commission or an authorized commission officer or employee must authorize the action. However, authorization under this subdivision does not require:

   (A) notice to the insurer;
   (B) opportunity for hearing; or
   (C) disclosure of:
       (i) requests for authorization; or
       (ii) records of the commission's action on a request described in item (i).


IC 27-8-31-10
Dispute resolution
Sec. 10. The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and that may arise between two (2) or more compacting states, or between compacting states and noncompacting states, and the commission shall adopt an operating procedure providing for resolution of any disputes.

IC 27-8-31-11
Product filing and approval
Sec. 11. (a) Insurers and third party filers seeking to have a product approved by the commission shall file the product with and pay applicable filing fees to the commission. Nothing in this chapter restricts or otherwise prevents an insurer from filing the insurer's product with the insurance department in any state where the insurer is licensed to conduct the business of insurance, and the filing is subject to the laws of the states where filed.

   (b) The commission shall establish appropriate filing and review processes and procedures under commission rules and operating procedures. Notwithstanding any provision in this chapter to the contrary, the commission shall adopt rules to establish conditions and
procedures under which the commission will provide public access to product filing information. In establishing any rules, the commission shall consider the interests of the public in having access to the information as well as protection of personal medical and financial information and trade secrets that may be contained in a product filing or supporting information.

(c) Any product approved by the commission may be sold or otherwise issued in the compacting states in which the insurer is legally authorized to do business.


IC 27-8-31-12
Disapproval; appeal; monitoring

Sec. 12. (a) Not later than thirty (30) days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall adopt rules to establish procedures for appointing the review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or an advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with section 3(e) of this chapter.

(b) The commission shall monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. If appropriate, the commission may withdraw or modify the commission's approval after proper notice and hearing, subject to the appeal process in subsection (a).


IC 27-8-31-13
Commission finances

Sec. 13. (a) The commission shall pay or provide for the payment of the reasonable expenses of the commission's establishment and organization. To fund the cost of the commission's initial operations, the commission may accept contributions and other forms of funding from the NAIC, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of the commission's duties is not compromised.

(b) The commission shall collect a filing fee from each insurer and third party filer filing a product with the commission to cover the cost of the operations and activities of the commission and the commission's staff in an amount sufficient to cover the commission's annual budget.

(c) The commission's budget for a fiscal year may not be approved until the commission's budget has been subject to notice and
(d) The commission is exempt from all taxation in and by the compacting states.

(e) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The commission shall keep complete and accurate accounts of all the commission's internal receipts, including grants and donations, and disbursements of all funds under the commission's control. The internal financial accounts of the commission are subject to the accounting procedures established under the commission's bylaws. The financial accounts and reports, including the system of internal controls and procedures of the commission, shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but not less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report, to the governor and legislature of the compacting states, including a report of the independent audit. The commission's internal accounts are not confidential and such internal account materials may be shared with the commissioner of any compacting state upon request. However, work papers related to internal or independent audit and information regarding the privacy of individuals and proprietary information of insurers, including trade secrets, is confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held under the provisions of this compact.


IC 27-8-31-14

Effectiveness of compact; amendments

Sec. 14. (a) Any state is eligible to become a compacting state. The compact becomes effective and binding upon legislative enactment of the compact into law by two (2) compacting states. However, the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of products filed with the commission that satisfy applicable uniform standards only after twenty-six (26) states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long term care insurance products, based on records of the NAIC for the prior year. Thereafter, it becomes effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(b) Amendments to the compact may be proposed by the commission for enactment by the compacting states. An amendment does not become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.
IC 27-8-31-15
Withdrawal of compacting state; reinstatement

Sec. 15. (a) Once effective, the compact continues in force and remains binding upon each compacting state. However, a compacting state may withdraw from the compact by enacting a statute specifically repealing the statute that enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal does not apply to any product filings approved or self-certified, or any advertisement of products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state, unless the approval is rescinded by the withdrawing state as provided in subsection (e).

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of the legislation within ten (10) days after the commission's receipt of notice of the introduction of the legislation.

(e) The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement before the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state occurs on the effective date of the withdrawing state reenacting the compact.


IC 27-8-31-16
Default of compacting state; reinstatement

Sec. 16. (a) If the commission determines that any compacting state has at any time defaulted in the performance of any of the compacting state's obligations or responsibilities under this compact, the bylaws, or adopted rules or operating procedures, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include:

(1) failure of a compacting state to perform its obligations or responsibilities; or
(2) any other grounds designated in commission rules.
The commission shall immediately notify the defaulting state in
writing of the defaulting state's suspension pending a cure of the
default. The commission shall stipulate the conditions and the period
within which the defaulting state must cure the defaulting state's
default. If the defaulting state fails to cure the default within the
period specified by the commission, the defaulting state shall be
terminated and the compact and all rights, privileges, and benefits
conferred by this compact shall be terminated on the effective date of
termination.

(b) Product approvals by the commission, product
self-certifications, or any advertisement in connection with the
product that is in force on the effective date of termination shall
remain in force in the defaulting state in the same manner as if the
defaulting state had withdrawn voluntarily under section 15 of this
chapter.

(c) Reinstatement following termination of any compacting state
requires a reenactment of the compact.

IC 27-8-31-17
Dissolution of compact
Sec. 17. The compact dissolves effective on the date of the
withdrawal or default of the compacting state that reduces
membership in the compact to one (1) compacting state. Upon the
dissolution of this compact, the compact is null and void and is of no
further force or effect, and the business and affairs of the commission
shall be wound up and any surplus funds shall be distributed in
accordance with the bylaws.

IC 27-8-31-18
Severability
Sec. 18. The provisions of this compact are severable and if any
phrase, clause, sentence, or provision is considered unenforceable,
the remaining provisions of the compact are enforceable. The
provisions of this compact shall be liberally construed to effectuate
the compact's purposes.

IC 27-8-31-19
Effect on state law
Sec. 19. (a) Nothing in this chapter prevents the enforcement of
any other law of a compacting state, except as provided in subsection
(b).

(b) For a product approved or certified to the commission, the
rules, uniform standards, and any other requirements of the
commission constitute the exclusive provisions applicable to the
content, approval, and certification of the products. For an
advertisement that is subject to the commission's authority, any rule,
uniform standard, or other requirement of the commission that
governs the content of the advertisement constitutes the exclusive
provision that a commissioner may apply to the content of the
advertisement. However, no action taken by the commission shall
abrogate or restrict:
(1) the access of any person to state courts;
(2) remedies available under state law related to breach of
contract, tort, or other laws not specifically directed to the
content of the product;
(3) state law relating to the construction of insurance contracts;
or
(4) the authority of the attorney general of the state, including
maintaining actions or proceedings, as authorized by law.
(c) All insurance products filed with individual states are subject
to the laws of those states.

IC 27-8-31-20
Commission actions and agreements; effect on compacting states;
constitutional violation
Sec. 20. (a) All lawful actions of the commission, including all
rules and operating procedures adopted by the commission, are
binding upon the compacting states.
(b) All agreements between the commission and the compacting
states are binding in accordance with the terms of the agreements.
(c) Upon the request of a party to a conflict over the meaning or
interpretation of commission actions and upon a majority vote of the
compacting states, the commission may issue advisory opinions
regarding the meaning or interpretation in dispute.
(d) Any provision of this compact that violates the Constitution of
the State of Indiana is ineffective in Indiana.
IC 27-8-31.2
Chapter 31.2. Mail Order and Internet Pharmacy Designation

IC 27-8-31.2-0.1
Application of chapter
Sec. 0.1. The addition of this chapter by P.L.251-2003 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.
As added by P.L.220-2011, SEC.453.

IC 27-8-31.2-1
"Insurer"
Sec. 1. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues a policy of accident and sickness insurance.

IC 27-8-31.2-2
"Insured"
Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

IC 27-8-31.2-3
"Mail order or Internet based pharmacy"
Sec. 3. As used in this chapter, "mail order or Internet based pharmacy" has the meaning set forth in IC 25-26-18-1.

IC 27-8-31.2-4
"Policy of accident and sickness insurance"
Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

IC 27-8-31.2-5
Designation of mail order or Internet based pharmacy
Sec. 5. (a) An insurer that provides coverage for prescription drugs may designate a mail order or an Internet based pharmacy to provide prescription drugs to an insured.
(b) An insurer may not require an insured to obtain a prescription drug from a pharmacy designated under subsection (a) as a condition of coverage.
IC 27-8-32
Chapter 32. Coverage for Chemotherapy

IC 27-8-32-1
Application of chapter
Sec. 1. This chapter applies to a policy of accident and sickness insurance that provides coverage for both of the following:
   (1) Orally administered cancer chemotherapy.
   (2) Cancer chemotherapy that is administered intravenously or by injection.

IC 27-8-32-2
"Cancer chemotherapy"
Sec. 2. As used in this chapter, "cancer chemotherapy" means medication that is prescribed by a physician to kill or slow the growth of cancer cells.

IC 27-8-32-3
"Insured"
Sec. 3. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

IC 27-8-32-4
"Policy of accident and sickness insurance"
Sec. 4. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

IC 27-8-32-5
Prohibition on coverage limitations
Sec. 5. Coverage for orally administered cancer chemotherapy under a policy of accident and sickness insurance must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for cancer chemotherapy that is administered intravenously or by injection under the policy of accident and sickness insurance.
IC 27-8-33
Chapter 33. Health Care Exchanges and Abortion

IC 27-8-33-1
"Abortion"
Sec. 1. As used in this chapter, "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.
As added by P.L.193-2011, SEC.16.

IC 27-8-33-2
"Federal Patient Protection and Affordable Care Act"
Sec. 2. As used in this chapter, "federal Patient Protection and Affordable Care Act" includes amendments made by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
As added by P.L.193-2011, SEC.16.

IC 27-8-33-3
"Qualified health plan"
Sec. 3. As used in this chapter, "qualified health plan" has the meaning set forth in Section 1301 of the federal Patient Protection and Affordable Care Act (P.L. 111-148).
As added by P.L.193-2011, SEC.16.

IC 27-8-33-4
Prohibition on coverage for abortion; exceptions
Sec. 4. A qualified health plan offered under Subtitle D of Title I of the federal Patient Protection and Affordable Care Act may not provide coverage for abortion, except in the following cases:
(1) The pregnant woman became pregnant through an act of rape or incest.
(2) An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
As added by P.L.193-2011, SEC.16.