Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

20(A) Non-Grandfathered
Small Group Major Medical & Dental
Small Business Health Option Program (SHOP) Major Medical and Dental

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

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

Company Name_____ **NAIC #** _____

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

Product Type:	☐	**Major Medical**	☐	**Pediatric Stand-Alone Dental**
Exchange Participation:	☐	**Off-Exchange**	☐	**On-Exchange**

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

Requirements in this checklist include:

Contents

Instructions:

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

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

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

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

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	**FILING DESCRIPTION/COVER/ LETTER/NAICTRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. P*lease acknowledge.*		
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	**The following rights of Insurers and insureds must be disclosed in group accident and sickness policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.**		
IC 27-8-5-19(c)(1)	**GRACE PERIOD**: The policyholder has a grace period of 31 days for payment of premium due, except the first premium. Policy remains in force during the grace period, but Insurer may hold claims incurred		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	during grace period until premium is received.		
IC 27-8-5-19(c)(2)	**INCONTESTABILITY**: Validity of policy may not be contested after 2 years except for a) nonpayment of premiums, or if b) the disputed statement is in a written instrument signed by insured. Ineligibility of insured or enrollee under the policy may be disputed any time.		
IC 27-8-5-19(c)(3)	**COPY OF APPLICATION**: If there is an application, a copy must be attached to the policy at issue. Statements made by persons insured are representations, not warranties, and must be provided to insured persons in case of a dispute.		
IC 27-8-5-19(c)(7)	**MISSTATEMENT OF AGE**: Clear statement of how premiums, benefits or both will be fairly adjusted if covered person's age is misstated and if premiums and benefits vary by age.		
IC 27-8-5-19(c)(8)	**CERTIFICATE**: Insurer must issue to policyholder, for delivery to each insured person, a certificate of coverage explaining the protection, to whom the benefits are payable, and each family member and dependent's coverage. (See below for debtor's certificate.)		
IC 27-8-5-19(c)(9)	**TIMELY NOTICE OF CLAIM**: Insured must provide written notice of claim within 20 days after occurrence or commencement of loss, or as soon as reasonably possible.		
IC 27-8-5-19(c)(10)	**CLAIM FORMS**: Insurer must provide forms for filing proof of loss within 15 days of notice of claim, or claimants can submit their own.		
IC 27-8-5-19(c)(11)	**PROOF OF LOSS**: Written proof must be furnished within 90 days of loss. Claim will not be reduced if proof was not reasonably possible but no later than 1 year after requirement.		
IC 27-8-5-19(c)(12) IC 27-8-5-3(a)(8) IC 27-8-5.7	**TIME OF PAYMENT OF CLAIMS**: Payment for any loss (other than loss for which the policy provides periodic payment) will be paid immediately upon receipt of due written proof of loss, OR an insurer shall pay		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	or deny each clean claim or notify the claimant of any deficiencies within 30 days if the claim is filed electronically or within 45 days if the claim is filed on paper, whichever is more favorable to the policyholder. If a policy provides for a periodic payment, it will not be paid less frequently than monthly. Any balance remaining unpaid upon the termination of liability when the policy provides periodic payment will be paid immediately upon receipt of due written proof.		
IC 27-8-5-19(c)(13)	**BENEFICIARIES**: Loss of life benefits are paid to the beneficiary designated by the insured. If the policy contains conditions pertaining to family status the policy terms apply. All other benefits payable to the person insured. Insurer may also choose to pay up to $5000 to a relative by blood or marriage if beneficiary is an estate or a minor. (Does not apply to policies insuring lives of debtors.)		
IC 27-8-5-19(c)(14)	**PHYSICAL EXAMINATION AND AUTOPSY**: Insurer has the right to examine the person during the pendency of a claim or to conduct an autopsy in case of death, unless prohibited by law.		
IC 27-8-5-19(c)(15)	**LEGAL ACTIONS**: No lawsuit may be filed to recover under the policy before 60 days after proof of loss is filed, and not later than 3 years after proof of loss is required to be filed.		
IC 27-8-5-19(c)(16)	**DEBTOR'S CERTIFICATE**: If policy insures debtors, the Insurer will furnish to policyholder a certificate of insurance for each debtor insured, describing the coverage and benefits payable first to reduce or extinguish indebtedness.		
IC 27-8-5-19	**INTELLECTUALLY DISABLED CHILDREN:** 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 as stated in the policy, it must also provide that a child's attainment of a limiting age does not terminate the hospital and medical coverage		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental, intellectual, or physical disability; and (b) chiefly dependent upon the policyholder for support and maintenance. May require that proof of 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.		
IC 27-8-28 IC 27-8-29	**GRIEVANCE AND APPEALS PROCEDURES**: Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals, and (3) external appeals, and the related time frames for each tier.		
Bulletin 128	**NOTICE**: Notice to policyholders regarding filing complaints with the Department of Insurance		
C. Optional Provisions			
760 IAC 1-38.1	Coordination of Benefits – Required language if included		
D. Group A&H Policies *Must Provide*			
IC 27-8-5-15.6	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-8-5-21	**ADOPTED CHILDREN**		
IC 27-8-5-26	**BREAST RECONSTRUCTION & PROSTHESIS** following mastectomy—regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-8-5-27	**DENTAL ANESTHESIA/ HOSPITALIZATION**		
IC 27-8-5-28 Bulletin 189	**DEPENDENTS TO AGE 26:** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		

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IC 27-8-5-30(h)	**PHARMACY STEP THERAPY EXCEPTION** Company must provide in writing a procedure for use in requesting an exception to a step therapy protocol that includes instructions for making the request and outlines the obligations of the carrier in making the determination and notification of the insured.		
IC 27-8-5.6-2(b)	**NEWBORNS**		
IC 27-8-14-6	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)		
Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDER (PREVIOUSLY PDD):** As Per Bulletins 136 and 179, "Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan." Autism Spectrum Disorders include Asperger's Syndrome and Autism.		
IC 27-8-14.5	**DIABETES TREATMENT**, supplies, equipment & education		
IC 27-8-14.7	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk) Due to EHB benchmark requirements, prostate cancer screening must be covered		
IC 27-8-14.8	**COLORECTAL CANCER SCREENING** Due to the EHB Benchmark requirements, colorectal cancer screening must be covered		
IC 27-8-24-4	**MINIMUM POSTPARTUM STAY AND INFANT SCREENING TESTS** required by IC 16-41		
IC 27-8-24.1-5	**INHERITED METABOLIC DISEASE**		
IC 27-8-24.2-5	**ORTHOTIC AND PROSTHETIC DEVICES**		
IC 27-8-24.3	**VICTIMS OF ABUSE** without regard to the abuse		
IC 27-8-26	Individuals without regard to **GENETIC TESTING**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**		
Bulletin 172	**CHEMOTHERAPY PARITY**		
760 IAC 1-39-7	**AIDS, HIV** and related conditions		
IC 27-8-34	**TELEMEDICINE** services means health care services delivered by use of interactive audio, video, or other electronic media, including (a) medical exams and consultations; and (b) behavioral health, including substance abuse evaluations and treatment. A policy must provide coverage for telemedicine at parity for the same health care services delivered in person. Coverage for telemedicine services may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual than the dollar limit, deductible, or coinsurance that applies to the same health care services delivered in person. Any annual or lifetime dollar limit that applies to telemedicine services must be the same as the annual or lifetime dollar limit that applies in the aggregate to all items and services covered under the policy.		
E. Group A&H Policies *Must Offer*			
IC 27-8-14.1	**MORBID OBESITY:** Coverage for the surgical treatment of morbid obesity. For groups that choose to offer this benefit on the exchange, any premium related to this benefit would not be eligible for premium tax credit.		
F. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1 and 27-8-5-1.5, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will also be reviewed.**		
IC 27-8-5-1.5(l)(2)	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.		

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IC 27-8-5-1.5(l)(2)	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-8-5-1.5(l)(2)	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be re-filed to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-8-5-1.5(l)(2)	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		
IC 27-8-5-1.5(l)(2)	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		
IC 27-8-5-1.5(l)(2)	**PRIVACY OF HEALTH INFORMATION:** Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.		
IC 27-8-5-1.5(l)(2)	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-2.5 IC 27-8-5-19(c)(6) IC 27-8-15-27	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		

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Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		
G. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302		
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302		
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included and excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please acknowledge* PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please acknowledge* PHSA §2728 45 CFR §147.145		
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel		

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	Management (OPM). *Please acknowledge* 45 CFR §156.122(a)		
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please acknowledge* PHSA §2715		
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(e)		
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the group market in Indiana it must offer to any employer in Indiana all products that are approved for sale and must accept any employer that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(a)		
IC 27-8-5-1(c)	**OPEN ENROLLMENT:** Insurer must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. Insurer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	defined in the Affordable Care Act and pursuant to applicable state law. If the plan is offered in SHOP, coverage must be effective consistent with the dates mandated by the SHOP Exchange even if plan is off Exchange. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b)		
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 30 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(b) 45 CFR §155.410		
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to employers if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract		

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	holders. (B) It is applying this section uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees, and dependents. (2) An Insurer that denies health insurance coverage to an employer in any service area may not offer coverage in the group market within the service area to any employer for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.104(c)		
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the group market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any employer in Indiana under the financial capacity limitations, it may not offer coverage in the group market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.104(d)		
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the group market in Indiana it must renew or		

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

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	markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please acknowledge* 45 CFR §147.106(d)		
IC 27-8-5-1(c)	**UNIFORM MODIFICATION OF COVERAGE:** Insurer may only modify coverage at the time of coverage renewal. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(e)		
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered in-network cost-sharing level		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		
H. Specific Requirements for Qualified Health Plans in SHOP	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		
	PARTICIPATION RULES: Insurers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP 45 CFR §156.285 (e)		
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	WAITING PERIODS: Group health plans may not impose waiting periods in excess of 90 days from the date on which an employee would be otherwise eligible for participation in the group health plan. Any special enrollment for newly eligible employees would occur at the expiration of any waiting period. PHSA §2708		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
I. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature:_____

Printed Name:_____

Title: _____

Company: _____

Date: _____