IC 5-10-8

Chapter 8. Group Insurance for Public Employees

IC 5-10-8-0.1

Application of certain amendments to chapter

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

(1) The amendments made to section 2 of this chapter (before its repeal) and section 3 of this chapter (before its repeal) by P.L.46-1985 do not affect contracts:

(A) entered into before; and

(B) in effect on;

July 1, 1986.

(2) The addition of section 7.2 of this chapter by P.L.35-1992 applies to a contract between the state and a prepaid health care delivery plan that is entered into or renewed after June 30, 1992.

(3) The amendments made to section 7.2 of this chapter by P.L.170-1999 apply to a self-insurance program or a contract between the state and a health maintenance organization established, entered into, or renewed after June 30, 1999.

(4) The addition of section 7.5 of this chapter by P.L.170-1999 applies to a self-insurance program or a contract between the state and a health maintenance organization established, entered into, or renewed after June 30, 1999.

(5) The addition of section 13 of this chapter by P.L.251-2003 applies to an employee health benefit plan that is entered into, issued, delivered, amended, or renewed after June 30, 2003.

(6) The amendments made to section 7.7 of this chapter by P.L.196-2005 apply to a self-insurance program or a contract with a prepaid health care delivery plan that is established, entered into, delivered, amended, or renewed after June 30, 2005.

(7) The addition of section 14 of this chapter by P.L.109-2008 applies to a state employee health plan that is established, entered into, delivered, amended, or renewed after June 30, 2008.

As added by P.L.220-2011, SEC.65.

IC 5-10-8-0.3

Use of certain accrued benefits by state employees

Sec. 0.3. The benefits accrued by an employee under 31 IAC 1-9-5 (before its repeal) or 31 IAC 2-11-6 (before its repeal) that are unused after June 30, 1989, may be used by the employee after June 30, 1989, in accordance with the rules required by section 7(d) of this chapter, as amended by P.L.27-1988. The rules required by section 7(d) of this chapter, as amended by P.L.27-1988, must provide that an employee who:

(1) is subject to section 7(d) of this chapter; and

(2) has less than five (5) years of continuous full-time employment after June 30, 1989;

will be credited with special sick leave on a pro rata basis after June 30, 1989.

As added by P.L.220-2011, SEC.66.

IC 5-10-8-0.4

Legalization of certain payments of deductible portion of group health insurance

Sec. 0.4. Payment of the deductible portion of group health insurance by a public employer before July 1, 1989, is legalized.

As added by P.L.220-2011, SEC.67.

IC 5-10-8-0.5

Repealed

(As added by P.L.220-2011, SEC.68. Repealed by P.L.91-2014, SEC.8.)

IC 5-10-8-1

Definitions

Sec. 1. The following definitions apply in this chapter:

(1) "Employee" means:

(A) an elected or appointed officer or official, or a full-time employee;

(B) if the individual is employed by a school corporation, a full-time or part-time employee;

(C) for a local unit public employer, a full-time or part-time employee or a person who provides personal services to the unit under contract during the contract period; or

(D) a senior judge appointed under IC 33-24-3-7;

whose services have continued without interruption at least thirty (30) days.

(2) "Group insurance" means any of the kinds of insurance fulfilling the definitions and requirements of group insurance contained in IC 27-1.

(3) "Insurance" means insurance upon or in relation to human life in all its forms, including life insurance, health insurance, disability insurance, accident insurance, hospitalization insurance, surgery insurance, medical insurance, and supplemental medical insurance.

(4) "Local unit" includes a city, town, county, township, public library, municipal corporation (as defined in IC 5-10-9-1), school corporation, or charter school.

(5) "New traditional plan" means a self-insurance program established under section 7(b) of this chapter to provide health care coverage.

(6) "Public employer" means the state or a local unit, including

any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit. With respect to the legislative branch of government, "public employer" or "employer" refers to the following:

(A) The president pro tempore of the senate, with respect to former members or employees of the senate.

(B) The speaker of the house, with respect to former members or employees of the house of representatives.

(C) The legislative council, with respect to former employees of the legislative services agency.

(7) "Public employer" does not include a state educational institution.

(8) "Retired employee" means:

(A) in the case of a public employer that participates in the public employees' retirement fund, a former employee who qualifies for a benefit under IC 5-10.3-8 or IC 5-10.2-4;

(B) in the case of a public employer that participates in the teachers' retirement fund under IC 5-10.4, a former employee who qualifies for a benefit under IC 5-10.4-5; and

(C) in the case of any other public employer, a former employee who meets the requirements established by the public employer for participation in a group insurance plan for retired employees.

(9) "Retirement date" means the date that the employee has chosen to receive retirement benefits from the employees' retirement fund.

As added by Acts 1980, P.L.8, SEC.41. Amended by P.L.39-1986, SEC.1; P.L.56-1989, SEC.1; P.L.39-1990, SEC.1; P.L.40-1990, SEC.1; P.L.233-1999, SEC.1; P.L.50-2000, SEC.1; P.L.13-2001, SEC.7; P.L.98-2004, SEC.65; P.L.2-2006, SEC.14; P.L.2-2007, SEC.81; P.L.194-2007, SEC.1; P.L.91-2011, SEC.1.

IC 5-10-8-2

Repealed

(Repealed by P.L.24-1985, SEC.25(c).)

IC 5-10-8-2.1

Repealed

(Repealed by P.L.1-1991, SEC.32.)

IC 5-10-8-2.2

Public safety employees; surviving spouses; dependents

Sec. 2.2. (a) As used in this section, "dependent" means a natural child, stepchild, or adopted child of a public safety employee who:

(1) is less than eighteen (18) years of age;

(2) is at least eighteen (18) years of age and has a physical or

mental disability (using disability guidelines established by the Social Security Administration); or

(3) is at least eighteen (18) and less than twenty-three (23) years of age and is enrolled in and regularly attending a secondary school or is a full-time student at an accredited college or university.

(b) As used in this section, "public safety employee" means a full-time firefighter, police officer, county police officer, or sheriff.

(c) This section applies only to local unit public employers and their public safety employees.

(d) A local unit public employer may provide programs of group health insurance for its active and retired public safety employees through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) If the local unit public employer is a school corporation, by electing to provide the coverage through a state employee health plan under section 6.7 of this chapter.

A local unit public employer may provide programs of group insurance other than group health insurance for the local unit public employer's active and retired public safety employees by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

(e) A local unit public employer may pay a part of the cost of group insurance for its active and retired public safety employees. However, a local unit public employer that provides group life insurance for its active and retired public safety employees shall pay a part of the cost of that insurance.

(f) A local unit public employer may not cancel an insurance contract under this section during the policy term of the contract.

(g) After June 30, 1989, a local unit public employer that provides a group health insurance program for its active public safety employees shall also provide a group health insurance program to the following persons:

(1) Retired public safety employees.

(2) Public safety employees who are receiving disability benefits under IC 36-8-6, IC 36-8-7, IC 36-8-7.5, IC 36-8-8, or IC 36-8-10.

(3) Surviving spouses and dependents of public safety employees who die while in active service or after retirement.

(h) A public safety employee who is retired or has a disability and is eligible for group health insurance coverage under subsection (g)(1) or (g)(2):

(1) may elect to have the person's spouse, dependents, or spouse and dependents covered under the group health insurance program at the time the person retires or becomes disabled;

(2) must file a written request for insurance coverage with the

employer within ninety (90) days after the person retires or begins receiving disability benefits; and

(3) must pay an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active public safety employee (however, the employer may elect to pay any part of the person's premiums).

(i) Except as provided in IC 36-8-6-9.7(f), IC 36-8-6-10.1(h), IC 36-8-7-12.3(g), IC 36-8-7-12.4(j), IC 36-8-7.5-13.7(h), IC 36-8-7.5-14.1(i), IC 36-8-8-13.9(d), IC 36-8-8-14.1(h), and IC 36-8-10-16.5 for a surviving spouse or dependent of a public safety employee who dies in the line of duty, a surviving spouse or dependent who is eligible for group health insurance under subsection (g)(3):

(1) may elect to continue coverage under the group health insurance program after the death of the public safety employee;

(2) must file a written request for insurance coverage with the employer within ninety (90) days after the death of the public safety employee; and

(3) must pay the amount that the public safety employee would have been required to pay under this section for coverage selected by the surviving spouse or dependent (however, the employer may elect to pay any part of the surviving spouse's or dependents' premiums).

(j) The eligibility for group health insurance under this section for a public safety employee who is retired or has a disability ends on the earlier of the following:

(1) When the public safety employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program for active public safety employees.

(k) A surviving spouse's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the surviving spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) The date of the surviving spouse's remarriage.

(4) When health insurance becomes available to the surviving spouse through employment.

(l) A dependent's eligibility for group health insurance under this section ends on the earliest of the following:

(1) When the dependent becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the unit providing the insurance terminates the health insurance program for active public safety employees.

(3) When the dependent no longer meets the criteria set forth in subsection (a).

(4) When health insurance becomes available to the dependent through employment.

(m) A public safety employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the local unit public employer for active public safety employees if the public safety employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(n) A local unit public employer may provide group health insurance for retired public safety employees or their spouses not covered by subsections (g) through (l) and may provide group health insurance that contains provisions more favorable to retired public safety employees and their spouses than required by subsections (g) through (l). A local unit public employer may provide group health insurance to a public safety employee who is on leave without pay for a longer period than required by subsection (m), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

As added by P.L.58-1989, SEC.2. Amended by P.L.41-1990, SEC.2; P.L.286-2001, SEC.1; P.L.86-2003, SEC.1; P.L.2-2005, SEC.15; P.L.99-2007, SEC.13; P.L.3-2008, SEC.24; P.L.182-2009(ss), SEC.65; P.L.91-2014, SEC.9.

IC 5-10-8-2.5

Repealed

(Repealed by P.L.14-1986, SEC.19.)

IC 5-10-8-2.6

Local unit public employers and employees; programs; self-insurance; payment of part of cost; noncancelability; retired employees

Sec. 2.6. (a) This section applies only to local unit public employers and their employees. This section does not apply to public safety employees, surviving spouses, and dependents covered by section 2.2 of this chapter.

(b) A public employer may provide programs of group insurance for its employees and retired employees. The public employer may, however, exclude part-time employees and persons who provide services to the unit under contract from any group insurance coverage that the public employer provides to the employer's full-time employees. A public employer may provide programs of group health insurance under this section through one (1) of the following methods:

(1) By purchasing policies of group insurance.

(2) By establishing self-insurance programs.

(3) If the local unit public employer is a school corporation, by electing to provide the coverage through a state employee health

plan under section 6.7 of this chapter.

A public employer may provide programs of group insurance other than group health insurance under this section by purchasing policies of group insurance and by establishing self-insurance programs. However, the establishment of a self-insurance program is subject to the approval of the unit's fiscal body.

(c) A public employer may pay a part of the cost of group insurance, but shall pay a part of the cost of group life insurance for local employees. A public employer may pay, as supplemental wages, an amount equal to the deductible portion of group health insurance as long as payment of the supplemental wages will not result in the payment of the total cost of the insurance by the public employer.

(d) An insurance contract for local employees under this section may not be canceled by the public employer during the policy term of the contract.

(e) After June 30, 1986, a public employer shall provide a group health insurance program under subsection (g) to each retired employee:

(1) whose retirement date is:

(A) after May 31, 1986, for a retired employee who was a teacher (as defined in IC 20-18-2-22) for a school corporation; or

(B) after June 30, 1986, for a retired employee not covered by clause (A);

(2) who will have reached fifty-five (55) years of age on or before the employee's retirement date but who will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

(3) who will have completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and

(4) who will have completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.

(f) A group health insurance program required by subsection (e) must be equal in coverage to that offered active employees and must permit the retired employee to participate if the retired employee pays an amount equal to the total of the employer's and the employee's premiums for the group health insurance for an active employee and if the employee, within ninety (90) days after the employee's retirement date, files a written request with the employer for insurance coverage. However, the employer may elect to pay any part of the retired employee's premiums.

(g) A retired employee's eligibility to continue insurance under subsection (e) ends when the employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when

the employer terminates the health insurance program. A retired employee who is eligible for insurance coverage under subsection (e) may elect to have the employee's spouse covered under the health insurance program at the time the employee retires. If a retired employee's spouse pays the amount the retired employee would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired employee. The surviving spouse's eligibility ends on the earliest of the following:

(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) Two (2) years after the date of the employee's death.

(4) The date of the spouse's remarriage.

(h) This subsection does not apply to an employee who is entitled to group insurance coverage under IC 20-28-10-2(b). An employee who is on leave without pay is entitled to participate for ninety (90) days in any group health insurance program maintained by the public employer for active employees if the employee pays an amount equal to the total of the employer's and the employee's premiums for the insurance. However, the employer may pay all or part of the employer's premium for the insurance.

(i) A public employer may provide group health insurance for retired employees or their spouses not covered by subsections (e) through (g) and may provide group health insurance that contains provisions more favorable to retired employees and their spouses than required by subsections (e) through (g). A public employer may provide group health insurance to an employee who is on leave without pay for a longer period than required by subsection (h), and may continue to pay all or a part of the employer's premium for the insurance while the employee is on leave without pay.

As added by P.L.1-1991, SEC.33. Amended by P.L.286-2001, SEC.2; P.L.1-2005, SEC.76; P.L.182-2009(ss), SEC.66; P.L.91-2014, SEC.10.

IC 5-10-8-2.7

Insurance of rostered volunteers

Sec. 2.7. (a) As used in this section, "rostered volunteer" means a volunteer:

(1) whose name has been entered on a roster of volunteers for a volunteer program operated by a local unit; and

(2) who has been approved by the proper authorities of the local unit.

The term does not include a volunteer firefighter (as defined in IC 36-8-12-2) or an inmate assigned to a correctional facility operated by the state or a local unit.

(b) As used in this section, "local unit" does not include a school

corporation.

(c) The fiscal body of a local unit may elect to provide insurance for rostered volunteers for life, accident, or sickness coverage.

As added by P.L.51-1993, SEC.1.

IC 5-10-8-3

Repealed

(Repealed by P.L.24-1985, SEC.25(c).)

IC 5-10-8-3.1

Employees withholding from salaries or wages; retired employees; assignment of part of retirement benefit

Sec. 3.1. (a) A public employer that contracts for a group insurance plan or establishes a self-insurance plan for its employees may withhold or cause to be withheld from participating employees' salaries or wages whatever part of the cost of the plan the employees are required to pay. The chief fiscal officer responsible for issuing paychecks or warrants to the employees shall make deductions from the individual employees' paychecks or warrants to pay the premiums for the insurance. Except as provided by section 7(d) of this chapter, the fiscal officer shall require written authorization from state employees, and may require written authorization from local employees, to make the deductions. One (1) authorization signed by an employee is sufficient authorization for the fiscal officer to continue to make deductions for this purpose until revoked in writing by the employee.

(b) A public employer that contracts for a group insurance plan or establishes a self-insurance plan for its retired employees may require that the retired employees pay any part of the cost of the plan that is not paid by the public employer. A retired employee may assign part or all of the retired employee's benefit payable under IC 5-10.3-8, IC 5-10.4-5, or any other retirement program for this required payment.

As added by P.L.24-1985, SEC.10. Amended by P.L.27-1988, SEC.3; P.L.2-2006, SEC.15.

IC 5-10-8-4

Discrimination as to form of insurance between certain employees; exception

Sec. 4. Self-insurance plans for state employees involving income disability insurance, principal amount accident insurance, or both, must not, as to the form or forms of the insurance, discriminate between the employees of any department, commission, board, division, facility, institution, authority, or other establishment, except that the contributions for the insurance and benefits from the insurance may be equitably graduated in relation to:

(1) the employment compensation schedule; and

(2) if actuarially justified, the employee's age.

As added by Acts 1980, P.L.8, SEC.41. Amended by P.L.24-1985, SEC.11; P.L.27-1988, SEC.4.

IC 5-10-8-5

Establishment of common and unified plan of group insurance

Sec. 5. Two (2) or more local public employers may establish a common and unified plan of group insurance for their employees, including retired local employees. The plan shall be effected through a trust, agency, or any other legal arrangement with careful accounting and fiscal responsibility.

As added by Acts 1980, P.L.8, SEC.41. Amended by P.L.24-1985, SEC.12.

IC 5-10-8-6

Establishment of common and unified plans by state law enforcement agencies; trust fund for prefunding state contributions and OPEB liability

Sec. 6. (a) The state police department, conservation officers of the department of natural resources, and the state excise police may establish common and unified plans of self-insurance for their employees, including retired employees, as separate entities of state government. These plans may be administered by a private agency, business firm, limited liability company, or corporation. Any modification to:

(1) eligibility requirements;

(2) required premiums; or

(3) any other plan provisions;

that increases the amount of the state's contribution to the plan or that increases the post-employment liability under the plan may not be made unless the modification is approved by the budget agency with an annual review of the modifications by the budget committee.

(b) Except as provided in this section and IC 5-10-14, the state agencies listed in subsection (a) may not pay as the employer part of benefits for any employee or retiree an amount greater than that paid for other state employees for group insurance.

(c) This subsection applies to a health benefit plan for an individual described in subsection (a). After June 30, 2011, at least one (1) time in each state fiscal year, the budget agency shall determine the average amount of contributions made under IC 5-10-8.5-15 and IC 5-10-8.5-16 to participants in a health reimbursement arrangement or other separate fund under IC 5-10-8.5 in the immediately preceding state fiscal year. In the state fiscal year beginning July 1, 2011, the amount determined under this section must exclude contributions made to persons described in IC 5-10-8.5-15(c) and IC 5-10-8.5-16(f). An amount equal to the average amount determined under this subsection multiplied by the number of participants (other than retired participants) in the plans described in subsection (a) shall be transferred to the plans described

in subsection (a). The amount transferred under this subsection shall be proportionally allocated to each plan relative to the number of members in each plan. The amount allocated to a plan under this subsection shall be allocated among the participants in the plan in the same manner as other employer contributions. Funds shall be used only to reduce unfunded other post-employment benefit (OPEB) liability and not to increase benefits or reduce premiums.

(d) Trust funds may be established to carry out the purposes of this section. A trust fund established under this subsection is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from a trust fund established under this subsection by the state board of finance, the budget agency, or any other state agency. Money in a trust fund established under this subsection does not revert to the state general fund at the end of any state fiscal year. A trust fund established under this subsection consists of appropriations, revenues, or transfers to the trust fund under IC 4-12-1. Contributions to a trust fund established under this subsection are irrevocable. A trust fund established under this subsection must be limited to providing prefunding of annual required contributions and to cover OPEB liability for covered individuals. Funds may be used only for these purposes and not to increase benefits or reduce premiums. A trust fund established under this subsection shall be established to comply with and be administered in a manner that satisfies the Internal Revenue Code requirements concerning a trust fund for prefunding annual required contributions and for covering OPEB liability for covered individuals. All assets in a trust fund established under this subsection:

(1) are dedicated exclusively to providing benefits to covered individuals and their beneficiaries according to the terms of the health plan; and

(2) are exempt from levy, sale, garnishment, attachment, or other legal process.

A trust fund established under this subsection shall be administered by the agency employing the covered individuals. The expenses of administering a trust fund established under this subsection shall be paid from money in the trust fund. The treasurer of state shall invest the money in a trust fund established under this subsection not currently needed to meet the obligations of the trust fund in the same manner as other public money may be invested.

As added by Acts 1980, P.L.8, SEC.41. Amended by Acts 1982, P.L.36, SEC.1; P.L.24-1985, SEC.13; P.L.14-1986, SEC.11; P.L.8-1993, SEC.53; P.L.24-2005, SEC.1; P.L.170-2005, SEC.15; P.L.1-2006, SEC.95; P.L.227-2007, SEC.55; P.L.229-2011, SEC.68; P.L.138-2012, SEC.2.

IC 5-10-8-6.5
General assembly members and former members

Sec. 6.5. (a) A member of the general assembly may elect to participate in either:

(1) the plan of self-insurance established by the state police department under section 6 of this chapter;

(2) the plan of self-insurance established by the state personnel department under section 7 of this chapter; or

(3) a prepaid health care delivery plan established under section 7 of this chapter.

(b) A former member of the general assembly who meets the criteria for participation in a group health insurance program provided under section 8(e) or 8.1 of this chapter may elect to participate in either:

(1) the plan of self-insurance established by the state police department under section 6 of this chapter; or

(2) a group health insurance program provided under section 8(e) or 8.1 of this chapter.

(c) A member of the general assembly or former member of the general assembly who chooses a plan described in subsection (a)(1) or (b)(1) shall pay any amount of both the employer and the employee share of the cost of the coverage that exceeds the cost of the coverage under the new traditional plan.

As added by P.L.233-1999, SEC.2.

IC 5-10-8-6.6

Repealed

(As added by P.L.286-2001, SEC.3. Amended by P.L.91-2014, SEC.11. Repealed by P.L.121-2016, SEC.7.)

IC 5-10-8-6.7

Election of state employee health care program by school corporation

Sec. 6.7. (a) As used in this section, "state employee health plan" means a:

(1) self-insurance program established under section 7(b) of this chapter; or

(2) contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter;

to provide group health coverage for state employees.

(b) The state personnel department shall allow a school corporation or charter school to elect to provide coverage of health care services for active and retired employees of the school corporation under any state employee health plan. If a school corporation or charter school elects to provide coverage of health care services for active and retired employees of the school corporation or charter school under a state employee health plan, it must provide coverage for all active and retired employees of the school corporation or charter school under the state employee health plan (other than any employees covered by an Indiana

comprehensive health insurance association policy or individuals who retire from the school corporation before July 1, 2010, or charter school before July 1, 2011) if coverage was provided for these employees under the prior policies.

(c) The following apply if a school corporation or charter school elects to provide coverage for active and retired employees of the school corporation or charter school under subsection (b):

(1) The state shall not pay any part of the cost of the coverage.

(2) The coverage provided to an active or retired school corporation or charter school employee under this section must be the same as the coverage provided to an active or retired state employee under the state employee health plan.

(3) Notwithstanding sections 2.2 and 2.6 of this chapter:

(A) the school corporation or charter school shall pay for the coverage provided to an active or retired school corporation or charter school employee under this section an amount not more than the amount paid by the state for coverage provided to an active or retired state employee under the state employee health plan; and

(B) an active or retired school corporation or charter school employee shall pay for the coverage provided to the active or retired school corporation or charter school employee under this section an amount that is at least equal to the amount paid by an active or retired state employee for coverage provided to the active or retired state employee under the state employee health plan.

However, this subdivision does not apply to contractual commitments made by a school corporation to individuals who retire before July 1, 2010, or by a charter school to individuals who retire before July 1, 2011.

(4) The school corporation or charter school shall pay any administrative costs of the school corporation's or charter school's participation in the state employee health plan.

(5) The school corporation or charter school shall provide the coverage elected under subsection (b) for a period of at least three (3) years beginning on the date the coverage of the school corporation or charter school employees under the state employee health plan begins.

(d) The state personnel department shall provide an enrollment period at least every thirty (30) days for a school corporation or charter school that elects to provide coverage under subsection (b).

(e) The state personnel department may adopt rules under IC 4-22-2 to implement this section.

(f) Neither this section nor a school corporation's or charter school's election to participate in a state employee health plan as provided in this section impairs the rights of an exclusive representative of the certificated or noncertificated employees of the school corporation or charter school to collectively bargain all

matters related to school employee health insurance programs and benefits.

As added by P.L.182-2009(ss), SEC.67. Amended by P.L.182-2009(ss), SEC.515; P.L.109-2010, SEC.1; P.L.91-2011, SEC.2; P.L.6-2012, SEC.26.

IC 5-10-8-6.8

Consolidation of certain school corporations; state employee health plan

Sec. 6.8. (a) This section applies to a school corporation that results from the consolidation, reorganization, or merger, after May 1, 2012, of:

(1) a school corporation that has elected to provide coverage of health care services for active and retired employees of the school corporation under a state employee health plan; and

(2) a school corporation that has not elected to provide coverage of health care services for active and retired employees of the school corporation under a state employee health plan.

(b) A school corporation that results from a consolidation, reorganization, or merger described in subsection (a) must allow an individual for whom the school corporation described in subsection (a)(1) had (as of the effective date of the consolidation, reorganization, or merger) health insurance liability under a state employee health plan to continue the individual's coverage under the state employee health plan for at least five (5) years, as long as the individual otherwise remains eligible for coverage under the plan.

(c) This SECTION expires January 1, 2018.

As added by P.L.145-2012, SEC.2.

IC 5-10-8-7

Group insurance; self-insurance; health services; disability plans; trust fund for prefunding state contributions and OPEB liability

Sec. 7. (a) The state, excluding state educational institutions, may not purchase or maintain a policy of group insurance, except:

(1) life insurance for the state's employees;

(2) long term care insurance under a long term care insurance policy (as defined in IC 27-8-12-5), for the state's employees; or

(3) an insurance policy that provides coverage that supplements coverage provided under a United States military health care plan.

(b) With the consent of the governor, the state personnel department may establish self-insurance programs to provide group insurance other than life or long term care insurance for state employees and retired state employees. The state personnel department may contract with a private agency, business firm, limited liability company, or corporation for administrative services. A commission may not be paid for the placement of the contract. The

department may require, as part of a contract for administrative services, that the provider of the administrative services offer to an employee terminating state employment the option to purchase, without evidence of insurability, an individual policy of insurance.

(c) Notwithstanding subsection (a), with the consent of the governor, the state personnel department may contract for health services for state employees through one (1) or more prepaid health care delivery plans.

(d) The state personnel department shall adopt rules under IC 4-22-2 to establish long term and short term disability plans for state employees (except employees who hold elected offices (as defined by IC 3-5-2-17)). The plans adopted under this subsection may include any provisions the department considers necessary and proper and must:

(1) require participation in the plan by employees with six (6) months of continuous, full-time service;

(2) require an employee to make a contribution to the plan in the form of a payroll deduction;

(3) require that an employee's benefits under the short term disability plan be subject to a thirty (30) day elimination period and that benefits under the long term plan be subject to a six (6) month elimination period;

(4) prohibit the termination of an employee who is eligible for benefits under the plan;

(5) provide, after a seven (7) day elimination period, eighty percent (80%) of base biweekly wages for an employee disabled by injuries resulting from tortious acts, as distinguished from passive negligence, that occur within the employee's scope of state employment;

(6) provide that an employee's benefits under the plan may be reduced, dollar for dollar, if the employee derives income from:

(A) Social Security;

(B) the public employees' retirement fund;

(C) the Indiana state teachers' retirement fund;

(D) pension disability;

(E) worker's compensation;

(F) benefits provided from another employer's group plan; or

(G) remuneration for employment entered into after the disability was incurred.

(The department of state revenue and the department of workforce development shall cooperate with the state personnel department to confirm that an employee has disclosed complete and accurate information necessary to administer subdivision (6).);

(7) provide that an employee will not receive benefits under the plan for a disability resulting from causes specified in the rules; and

(8) provide that, if an employee refuses to:

(A) accept work assignments appropriate to the employee's medical condition;

(B) submit information necessary for claim administration; or

(C) submit to examinations by designated physicians;

the employee forfeits benefits under the plan.

(e) This section does not affect insurance for retirees under IC 5-10.3 or IC 5-10.4.

(f) The state may pay part of the cost of self-insurance or prepaid health care delivery plans for its employees.

(g) A state agency may not provide any insurance benefits to its employees that are not generally available to other state employees, unless specifically authorized by law.

(h) The state may pay a part of the cost of group medical and life coverage for its employees.

(i) To carry out the purposes of this section, a trust fund may be established. The trust fund established under this subsection is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the trust fund established under this subsection by the state board of finance, the budget agency, or any other state agency. Money in a trust fund established under this subsection does not revert to the state general fund at the end of any state fiscal year. The trust fund established under this subsection consists of appropriations, revenues, or transfers to the trust fund under IC 4-12-1. Contributions to the trust fund are irrevocable. The trust fund must be limited to providing prefunding of annual required contributions and to cover OPEB liability for covered individuals. Funds may be used only for these purposes and not to increase benefits or reduce premiums. The trust fund shall be established to comply with and be administered in a manner that satisfies the Internal Revenue Code requirements concerning a trust fund for prefunding annual required contributions and for covering OPEB liability for covered individuals. All assets in the trust fund established under this subsection:

(1) are dedicated exclusively to providing benefits to covered individuals and their beneficiaries according to the terms of the health plan; and

(2) are exempt from levy, sale, garnishment, attachment, or other legal process.

The trust fund established under this subsection shall be administered by the state personnel department. The expenses of administering the trust fund shall be paid from money in the trust fund. The treasurer of state shall invest the money in the trust fund not currently needed to meet the obligations of the trust fund in the same manner as other public money may be invested.

As added by P.L.28-1983, SEC.50. Amended by P.L.24-1985, SEC.14; P.L.39-1986, SEC.4; P.L.14-1986, SEC.12; P.L.27-1988, SEC.5; P.L.8-1993, SEC.54; P.L.21-1995, SEC.10; P.L.14-1996,

SEC.5; P.L.41-1997, SEC.1; P.L.286-2001, SEC.4; P.L.2-2006, SEC.16; P.L.158-2006, SEC.2; P.L.2-2007, SEC.82; P.L.138-2012, SEC.3; P.L.91-2014, SEC.12; P.L.121-2016, SEC.8.

IC 5-10-8-7.1

Coverage for autism spectrum disorder

Sec. 7.1. (a) As used in this section, "covered individual" means an individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to health services under a contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(b) As used in this section, "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.

(c) A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide a covered individual with coverage for the treatment of an autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the covered individual's treating physician in accordance with a treatment plan. A self-insurance program 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 or health plan solely because the individual is diagnosed with an autism spectrum disorder.

(d) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter must provide a covered individual with services for the treatment of an autism spectrum disorder. Services provided under this section are limited to treatment that is prescribed by the covered individual's treating physician in accordance with a treatment plan. A prepaid health care delivery plan may not deny or refuse to provide services to, or refuse to renew, refuse to reissue, or otherwise terminate or restrict services to, an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) The coverage required by subsection (c) and services required by subsection (d) may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to a covered individual than the dollar limits, deductibles, copayments, or coinsurance provisions that apply to physical illness generally under the self-insurance program or contract with a prepaid health care delivery plan.

As added by P.L.148-2001, SEC.1. Amended by P.L.188-2013, SEC.2.

IC 5-10-8-7.2

Breast cancer; definitions; self-insurance programs; health maintenance organizations; diagnostic services

Sec. 7.2. (a) As used in this section, "breast cancer diagnostic service" means a procedure intended to aid in the diagnosis of breast cancer. The term includes procedures performed on an inpatient basis and procedures performed on an outpatient basis, including the following:

(1) Breast cancer screening mammography.

(2) Surgical breast biopsy.

(3) Pathologic examination and interpretation.

(b) As used in this section, "breast cancer outpatient treatment services" means procedures that are intended to treat cancer of the human breast and that are delivered on an outpatient basis. The term includes the following:

(1) Chemotherapy.

(2) Hormonal therapy.

(3) Radiation therapy.

(4) Surgery.

(5) Other outpatient cancer treatment services prescribed by a physician.

(6) Medical follow-up services related to the procedures set forth in subdivisions (1) through (5).

(c) As used in this section, "breast cancer rehabilitative services" means procedures that are intended to improve the results of or to ameliorate the debilitating consequences of the treatment of breast cancer and that are delivered on an inpatient or outpatient basis. The term includes the following:

(1) Physical therapy.

(2) Psychological and social support services.

(3) Reconstructive plastic surgery.

(d) As used in this section, "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.

The term includes the interpretation of the results of a breast cancer screening mammography by a physician.

(e) As used in this section, "covered individual" means a female individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

(f) As used in this section, "mammography services provider" means an individual 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) is certified by the federal Department of Health and Human Services for participation in the Medicare program (42 U.S.C. 1395 et seq.).

(g) As used in this section, "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.

(h) A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide covered individuals with coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services. The coverage 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. The costs of the coverage required by this subsection may be paid by the state or by the employee or by a combination of the state and the employee.

(i) A contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter must provide covered individuals with breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(j) The coverage required by subsection (h) and services required by subsection (i) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to covered individuals than the dollar limits, deductibles, or coinsurance provisions applying to physical illness generally under the self-insurance program or contract with a health maintenance organization.

(k) The coverage for breast cancer diagnostic services required by subsection (h) and the breast cancer diagnostic services required by subsection (i) must include the following:

(1) In the case of a covered individual who is at least thirty-five (35) years of age but less than forty (40) years of age, at least

one (1) baseline breast cancer screening mammography performed upon the individual before she becomes forty (40) years of age.

(2) In the case of a covered individual who is:

(A) less than forty (40) years of age; and

(B) a woman at risk;

at least one (1) breast cancer screening mammography performed upon the covered individual every year.

(3) In the case of a covered individual who is at least forty (40) years of age, at least one (1) breast cancer screening mammography performed upon the individual 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 covered individual.

(l) The coverage for breast cancer diagnostic services required by subsection (h) and the breast cancer diagnostic services required by subsection (i) shall be provided in addition to any benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

As added by P.L.35-1992, SEC.1. Amended by P.L.26-1994, SEC.1; P.L.170-1999, SEC.1.

IC 5-10-8-7.3

Early intervention services for first steps children

Sec. 7.3. (a) As used in this section, "covered individual" means an individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(b) As used in this section, "early intervention services" means services provided to a first steps child under IC 12-12.7-2 and 20 U.S.C. 1432(4).

(c) As used in this section, "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 a covered individual.

(d) As used in this section, "first steps program" refers to 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.

(e) As used in this section, "health benefits plan" means a:

(1) self-insurance program established under section 7(b) of this

chapter to provide group health coverage; or

(2) contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(f) A health benefits 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 established by IC 12-9-1-1. The monthly fee shall be provided instead of claims processing of individual claims.

(g) The reimbursement required under subsection (f) may not be applied to any annual or aggregate lifetime limit on the first steps child's coverage under the health benefits plan.

(h) The first steps program may pay required deductibles, copayments, or other out-of-pocket expenses for a first steps child directly to a provider. A health benefits plan shall apply any payments made by the first steps program to the health benefits plan's deductibles, copayments, or other out-of-pocket expenses according to the terms and conditions of the health benefits plan.

As added by P.L.121-1999, SEC.1. Amended by P.L.246-2005, SEC.47; P.L.93-2006, SEC.2; P.L.229-2011, SEC.69.

IC 5-10-8-7.5

Prostate specific antigen test

Sec. 7.5. (a) As used in this section, "covered individual" means a male individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

(b) As used in this section, "prostate specific antigen test" means a standard blood test performed to determine the level of prostate specific antigen in the blood.

(c) A self-insurance program established under section 7(b) of this chapter to provide health care coverage must provide covered individuals with coverage for prostate specific antigen testing.

(d) A contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter must provide covered individuals with prostate specific antigen screening.

(e) The coverage required under subsections (c) and (d) must include the following:

(1) At least one (1) prostate specific antigen test annually for a covered individual who is at least fifty (50) years of age.

(2) At least one (1) prostate specific antigen test annually for a covered individual 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.

(f) The coverage required under this section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that

are less favorable to covered individuals than the dollar limits, deductibles, copayments, or coinsurance provisions applying to physical illness generally under the self-insurance program or contract with a health maintenance organization.

(g) The coverage for prostate specific antigen screening shall be provided in addition to benefits specifically provided for x-rays, laboratory testing, or wellness examinations.

As added by P.L.170-1999, SEC.2.

IC 5-10-8-7.7

Surgical treatment for morbid obesity

Sec. 7.7. (a) As used in this section, "covered individual" means an individual who is covered under a health care plan.

(b) As used in this section, "health care plan" means:

(1) a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) a contract entered into under section 7(c) of this chapter to provide health services through a prepaid health care delivery plan.

(c) As used in this section, "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.

(d) As used in this section, "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 subsection, body mass index is equal to weight in kilograms divided by height in meters squared.

(e) Except as provided in subsection (f), the state shall provide 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.

(f) The state may not provide coverage for surgical treatment of morbid obesity for a covered individual 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 covered individual; or

(2) restore the covered individual's ability to maintain a major life activity (as defined in IC 4-23-29-6);

and each physician documents in the covered individual's medical

record the reason for the physician's determination.
As added by P.L.78-2000, SEC.1. Amended by P.L.196-2005, SEC.1; P.L.102-2006, SEC.1.

IC 5-10-8-7.8
Colorectal cancer testing coverage

Sec. 7.8. (a) As used in this section, "covered individual" means an individual who is:

(1) covered under a self-insurance program established under section 7(b) of this chapter to provide group health coverage; or

(2) entitled to services under a contract with a health maintenance organization (as defined in IC 27-13-1-19) that is entered into or renewed under section 7(c) of this chapter.

(b) A:

(1) self-insurance program established under section 7(b) of this chapter to provide health care coverage; or

(2) contract with a health maintenance organization that is entered into or renewed under section 7(c) of this chapter;

must provide coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with the current American Cancer Society guidelines.

(c) For a covered individual 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 (d).

(d) A covered individual may not be required to pay an additional 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 a self-insurance program or contract with a health maintenance organization. If the program or contract 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.
As added by P.L.54-2000, SEC.1.

IC 5-10-8-8
Retired employees; ability of employer to pay premiums

Sec. 8. (a) This section applies only to the state and employees who are not covered by a plan established under section 6 of this chapter.

(b) After June 30, 1986, the state shall provide a group health insurance plan to each retired employee:

(1) whose retirement date is:

(A) after June 29, 1986, for a retired employee who was a member of the field examiners' retirement fund;

(B) after May 31, 1986, for a retired employee who was a member of the Indiana state teachers' retirement fund; or

(C) after June 30, 1986, for a retired employee not covered by clause (A) or (B);

(2) who will have reached fifty-five (55) years of age on or before the employee's retirement date but who will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(3) who:

(A) for an employee who retires before January 1, 2007, will have completed:

(i) twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which shall have been completed immediately preceding the retirement; and

(ii) at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date; or

(B) for an employee who retires after December 31, 2006, will have completed fifteen (15) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which shall have been completed immediately preceding the retirement.

(c) The state shall provide a group health insurance program to each retired employee:

(1) who is a retired judge;

(2) whose retirement date is after June 30, 1990;

(3) who is at least sixty-two (62) years of age;

(4) who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(5) who has at least eight (8) years of service credit as a participant in the Indiana judges' retirement fund, with at least eight (8) years of that service credit completed immediately preceding the judge's retirement.

(d) The state shall provide a group health insurance program to each retired employee:

(1) who is a retired participant under the prosecuting attorneys retirement fund;

(2) whose retirement date is after January 1, 1990;

(3) who is at least sixty-two (62) years of age;

(4) who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(5) who has at least ten (10) years of service credit as a participant in the prosecuting attorneys retirement fund, with at least ten (10) years of that service credit completed immediately preceding the participant's retirement.

(e) The state shall make available a group health insurance program to each former member of the general assembly or surviving spouse of each former member, if the former member:

(1) is no longer a member of the general assembly;

(2) is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq. or, in the case of a surviving spouse, the surviving spouse is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(3) has at least ten (10) years of service credit as a member in the general assembly.

A former member or surviving spouse of a former member who obtains insurance under this section is responsible for paying both the employer and the employee share of the cost of the coverage.

(f) The group health insurance program required under subsections (b) through (e) and subsection (k) must be equal to that offered active employees. The retired employee may participate in the group health insurance program if the retired employee pays an amount equal to the employer's and the employee's premium for the group health insurance for an active employee and if the retired employee within ninety (90) days after the employee's retirement date files a written request for insurance coverage with the employer. Except as provided in subsection (l), the employer may elect to pay any part of the retired employee's premium with respect to insurance coverage under this chapter.

(g) Except as provided in subsection (j), a retired employee's eligibility to continue insurance under this section ends when the employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program. A retired employee who is eligible for insurance coverage under this section may elect to have the employee's spouse covered under the health insurance program at the time the employee retires. If a retired employee's spouse pays the amount the retired employee would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired employee. The surviving spouse's eligibility ends on the earliest of the following:

(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) Two (2) years after the date of the employee's death.

(4) The date of the spouse's remarriage.

(h) This subsection does not apply to an employee who is entitled to group insurance coverage under IC 20-28-10-2(b). An employee who is on leave without pay is entitled to participate for ninety (90) days in any health insurance program maintained by the employer for active employees if the employee pays an amount equal to the total

of the employer's and the employee's premiums for the insurance.

(i) An employer may provide group health insurance for retired employees or their spouses not covered by this section and may provide group health insurance that contains provisions more favorable to retired employees and their spouses than required by this section. A public employer may provide group health insurance to an employee who is on leave without pay for a longer period than required by subsection (h).

(j) An employer may elect to permit former employees and their spouses, including surviving spouses, to continue to participate in a group health insurance program under this chapter after the former employee (who is otherwise qualified under this chapter to participate in a group insurance program) or spouse has become eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(k) The state shall provide a group health insurance program to each retired employee:

(1) who was employed as a teacher in a state institution under:
(A) IC 11-10-5;
(B) IC 12-24-3;
(C) IC 16-33-3;
(D) IC 16-33-4;
(E) IC 20-21-2-1; or
(F) IC 20-22-2-1;

(2) who is at least fifty-five (55) years of age on or before the employee's retirement date;

(3) who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

(4) who:
(A) has at least fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or
(B) completes at least ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement.

(l) The president pro tempore of the senate and the speaker of the house of representatives may not elect to pay any part of the premium for insurance coverage under this chapter for a former member of the general assembly or the spouse of a former member of the general assembly whose last day of service as a member of the general assembly is after July 31, 2007.

As added by P.L.39-1986, SEC.5. Amended by P.L.42-1990, SEC.1; P.L.67-1995, SEC.1; P.L.233-1999, SEC.3; P.L.13-2001, SEC.8; P.L.1-2005, SEC.77; P.L.178-2006, SEC.3; P.L.43-2007, SEC.12; P.L.91-2014, SEC.13.

IC 5-10-8-8.1
Retired legislators

Sec. 8.1. (a) This section applies only to the state and former legislators.

(b) As used in this section, "legislator" means a member of the general assembly.

(c) After June 30, 1988, the state shall provide to each retired legislator:

(1) whose retirement date is after June 30, 1988;

(2) who is not participating in a group health insurance coverage plan:

(A) including Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; but

(B) not including a group health insurance plan provided by the state or a health insurance plan provided under IC 27-8-10;

(3) who served as a legislator for at least ten (10) years; and

(4) who participated in a group health insurance plan provided by the state on the legislator's retirement date;

a group health insurance program that is equal to that offered active employees.

(d) A retired legislator who qualifies under subsection (c) may participate in the group health insurance program if the retired legislator:

(1) pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee; and

(2) within ninety (90) days after the legislator's retirement date files a written request for insurance coverage with the employer.

(e) Except as provided in section 8(j) of this chapter, a retired legislator's eligibility to continue insurance under this section ends when the member becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program.

(f) A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program at the time the legislator retires. If a retired legislator's spouse pays the amount the retired legislator would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. Except as provided in section 8(j) of this chapter, the spouse's eligibility ends on the earliest of the following:

(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) The date of the spouse's remarriage.

(g) The surviving spouse of a legislator who dies or has died in office may elect to participate in the group health insurance program if all of the following apply:

(1) The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the day of the legislator's death.

(2) The surviving spouse files a written request for insurance coverage with the employer.

(3) The surviving spouse pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee.

(h) Except as provided in section 8(j) of this chapter, the eligibility of the surviving spouse of a legislator to purchase group health insurance under subsection (g) ends on the earliest of the following:

(1) When the employer terminates the health insurance program.

(2) The date of the spouse's remarriage.

(3) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

As added by P.L.43-1988, SEC.2. Amended by P.L.36-1992, SEC.1; P.L.22-1998, SEC.2; P.L.233-1999, SEC.4; P.L.13-2001, SEC.9.

IC 5-10-8-8.2

Former legislators

Sec. 8.2. (a) As used in this section, "former legislator" means a former member of the general assembly.

(b) As used in this section, "dependent" means an unmarried person who:

(1) is:

(A) a dependent child, stepchild, foster child, or adopted child of a former legislator or spouse of a former legislator; or

(B) a child who resides in the home of a former legislator or spouse of a former legislator who has been appointed legal guardian for the child; and

(2) is:

(A) less than twenty-three (23) years of age;

(B) at least twenty-three (23) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or spouse of a former legislator for support and maintenance; or

(C) at least twenty-three (23) years of age and less than twenty-five (25) years of age and is enrolled in and is a full-time student at an accredited college or university.

(c) As used in this section, "spouse" means a person who is or was

married to a former legislator.

(d) After June 30, 2001, the state shall provide to a former legislator:

(1) whose last day of service as a member of the general assembly was after December 31, 2000;

(2) who served in all or part of at least four (4) terms of the general assembly (as defined in IC 2-2.1-1-1);

(3) who pays an amount equal to the employee's and employer's premium for the group health insurance for an active employee; and

(4) who files a written request for insurance coverage with the employer within ninety (90) days after the former legislator's:

(A) last day of service as a member of the general assembly; or

(B) retirement date;

a group health insurance program that is equal to that offered to active employees.

(e) Except as provided by section 8(j) of this chapter, the eligibility of a former legislator to continue insurance under this section ends when the former legislator becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq. or when the employer terminates the health insurance program.

(f) A former legislator who is eligible for insurance coverage under this section may elect to have a spouse or dependent of the former legislator covered under the health insurance program. A former legislator who makes an election under this subsection must pay the employee's and employer's premium for the group health insurance program for an active employee that is attributable to the inclusion of a spouse or dependent.

(g) A spouse or dependent may continue insurance under this section after the death of the former legislator if the spouse or dependent pays the amount the former legislator would have been required to pay for coverage selected by the spouse or dependent.

(h) Except as provided under section 8(j) of this chapter, the eligibility of a spouse to continue insurance under this section ends on the earliest of the following:

(1) When the employer terminates the health insurance program.

(2) The date of the legislative spouse's remarriage.

(3) When the required amount for coverage is not paid with respect to the spouse.

(4) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(i) The eligibility of a dependent to continue insurance under this section ends on the earliest of the following:

(1) When the employer terminates the health insurance program.

(2) The date the dependent no longer meets the definition of a

dependent.

(3) When the required amount for coverage is not paid with respect to the dependent.

(j) The spouse of a deceased former legislator may elect to participate in the group health insurance program under this section if all of the following apply:

(1) The deceased legislator:

(A) died after December 31, 2000, while serving as a member of the general assembly; and

(B) served in all or part of at least four (4) terms of the general assembly (as defined in IC 2-2.1-1-1).

(2) The surviving spouse files a written request for insurance coverage with the employer.

(3) The surviving spouse pays an amount equal to the employee's and employer's premium for the group health insurance for an active employee, including any amount with respect to covered dependents of the former legislator.

(k) Except as provided under section 8(j) of this chapter, the eligibility of the surviving spouse under subsection (j) ends on the earliest of the following:

(1) When the employer terminates the health insurance program.

(2) The date of the spouse's remarriage.

(3) When the required amount for coverage is not paid with respect to the spouse and any covered dependent.

(4) When the surviving spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

As added by P.L.13-2001, SEC.10. Amended by P.L.1-2007, SEC.26.

IC 5-10-8-8.3

Former state and legislative employees; health benefit plans

Sec. 8.3. (a) As used in this section, "department" refers to the state personnel department.

(b) The department shall establish, or contract for the establishment of, at least two (2) retiree health benefit plans to be available for former employees of:

(1) the state; and

(2) the legislative branch of government;

whose employer elects under section 8(j) of this chapter to permit its former employees to continue to participate in a health insurance program under this chapter after the employees have become eligible for Medicare coverage. At least one (1) of the plans offered to former employees must include coverage for prescription drugs comparable to a Medicare plan that provides prescription drug benefits. This subsection expires July 1, 2014.

(c) The department shall not, after June 30, 2014, amend or renew a retiree health benefit plan described in subsection (b) that is in effect on June 30, 2014.

(d) A retiree health benefit plan described in subsection (b) that is in effect on June 30, 2014, terminates on the first plan renewal date occurring after June 30, 2014.

As added by P.L.13-2001, SEC.11. Amended by P.L.91-2014, SEC.14.

IC 5-10-8-8.4

Revocation or alteration by employer

Sec. 8.4. Except as provided by an enactment of the general assembly, an election by an employer under:

(1) section 8(f) of this chapter concerning the payment of a retired employee's premium; or

(2) section 8(j) of this chapter concerning Medicare coverage and program eligibility;

may not be revoked or altered at any time by the employer or a subsequent employer to the detriment of a person entitled to benefits under section 8.2 of this chapter.

As added by P.L.184-2001, SEC.6.

IC 5-10-8-8.5

Establishment of retiree health benefit trust fund

Sec. 8.5. (a) The retiree health benefit trust fund is established to provide funding for a retiree health benefit plan developed under IC 5-10-8.5.

(b) The trust fund shall be administered by the budget agency. The expenses of administering the trust fund shall be paid from money in the trust fund. The trust fund consists of cigarette tax revenues deposited in the fund under IC 6-7-1-28.1(7) and other appropriations, revenues, or transfers to the trust fund under IC 4-12-1.

(c) The treasurer of state shall invest the money in the trust fund not currently needed to meet the obligations of the trust fund in the same manner as other public money may be invested.

(d) The trust fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the trust fund by the state board of finance, the budget agency, or any other state agency.

(e) The trust fund shall be established and administered in a manner that complies with Internal Revenue Code requirements concerning health reimbursement arrangement (HRA) trusts. Contributions by the state to the trust fund are irrevocable. All assets held in the trust fund must be held for the exclusive benefit of participants of the retiree health benefit plan developed under IC 5-10-8.5 and their beneficiaries. All assets in the trust fund:

(1) are dedicated exclusively to providing benefits to participants of the plan and their beneficiaries according to the terms of the plan; and

(2) are exempt from levy, sale, garnishment, attachment, or

other legal process.

(f) Money in the trust fund does not revert to the state general fund at the end of any state fiscal year.

(g) The money in the trust fund is appropriated to the budget agency for providing the retiree health benefit plan developed under IC 5-10-8.5.

As added by P.L.182-2009(ss), SEC.68.

IC 5-10-8-9

Coverage of services for mental illness

Sec. 9. (a) This section does not apply if the application of this section would increase the premiums of the health services policy or plan, as certified under IC 27-8-5-15.7, by more than four percent (4%) as a result of complying with subsection (c).

(b) As used in this section, "coverage of services for mental illness" includes benefits with respect to mental health services as defined by the contract, policy, or plan for health services. The term includes services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness.

(c) If the state enters into a contract for health services through prepaid health care delivery plans, medical self-insurance, or group health insurance for state employees, the contract may not permit treatment limitations or financial requirements on the coverage of services for mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(d) This section applies to a contract for health services through prepaid health care delivery plans, medical self-insurance, or group medical coverage for state employees that is issued, entered into, or renewed after June 30, 1997.

(e) This section does not require the contract for health services to offer mental health benefits.

As added by P.L.42-1997, SEC.1. Amended by P.L.81-1999, SEC.1; P.L.291-2001, SEC.230.

IC 5-10-8-10

Examining infants for HIV; payment

Sec. 10. (a) The state shall cover the testing required under IC 16-41-6-4 and the examinations required under IC 16-41-17-2 under a:

(1) self-insurance program established or maintained under section 7(b) of this chapter to provide group health coverage; and

(2) contract entered into or renewed under section 7(c) of this chapter to provide health services through a prepaid health care delivery plan.

(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.

As added by P.L.91-1999, SEC.1. Amended by P.L.237-2003, SEC.1.

IC 5-10-8-10.5

Dental care provisions required

Sec. 10.5. (a) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(b) As used in this section, "covered individual" means a child or an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; or

(2) who:

(A) has a record of; or

(B) is regarded as;

having an impairment described in subdivision (1).

(c) If the state enters into a contract for basic health care services (as defined in IC 27-13-1-4) through prepaid health care delivery plans, medical self-insurance, or group health insurance for state employees, the contract must include coverage for anesthesia and hospital charges for dental care for a covered individual if the mental or physical condition of the covered individual 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 covered individual's condition under general anesthesia constitutes appropriate treatment.

(d) A health care contractor that issues a contract for basic health care services as described in subsection (c) 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.

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

As added by P.L.189-1999, SEC.1.

IC 5-10-8-11

Use of diagnostic or procedure codes

Sec. 11. (a) As used in this section, "administrator" means:

(1) the state personnel department;

(2) an entity with which the state contracts to administer health coverage under section 7(b) of this chapter; or

(3) a prepaid health care delivery plan with which the state contracts under section 7(c) of this chapter.

(b) As used in this section, "health care plan" has the meaning set forth in section 7.7 of this chapter.

(c) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.

(d) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) an administrator 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 administrator pays claims for services provided under a health care plan; 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 a health care plan.

(e) If a provider provides services that are covered under a health care plan:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (d); and

(2) before the administrator begins using the most current version of the diagnostic or procedure code;

the administrator 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.

As added by P.L.161-2001, SEC.1. Amended by P.L.66-2002, SEC.1.

IC 5-10-8-12

Department report of the number of stimulant medication prescriptions for covered children diagnosed with certain disorders

Sec. 12. (a) As used in this section, "covered individual" means

an individual who is covered under an employee health plan.

(b) As used in this section, "employee health plan" means:

(1) a self-insurance program established under section 7(b) of this chapter; or

(2) a contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter;

that provides a prescription drug benefit.

(c) The state personnel department may report to the drug utilization review board established by IC 12-15-35-19, not later than October 1 of each calendar year, 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.

As added by P.L.107-2002, SEC.3.

IC 5-10-8-13

Mail order or Internet based pharmacy

Sec. 13. (a) As used in this section, "covered individual" means an individual who is entitled to coverage under an employee health benefit plan.

(b) As used in this section, "employee health benefit plan" means a group plan of self-insurance, policy, or contract that:

(1) provides coverage for prescription drugs; and

(2) is established, purchased, or entered into by an employer for the benefit of the employer's employees.

(c) As used in this section, "employer" means the following:

(1) A public employer.

(2) A state educational institution.

(d) As used in this section, "mail order or Internet based pharmacy" has the meaning set forth in IC 25-26-18-1.

(e) An employee health benefit plan that provides coverage for prescription drugs may designate a mail order or an Internet based pharmacy to provide prescription drugs to a covered individual.

(f) An employee health benefit plan may not require a covered individual to obtain a prescription drug from a pharmacy designated under subsection (e) as a condition of coverage.

As added by P.L.251-2003, SEC.1. Amended by P.L.2-2007, SEC.83.

IC 5-10-8-14

Coverage for prosthetic devices

Sec. 14. (a) As used in this section, "covered individual" means an individual who is entitled to coverage under a state employee health plan.

(b) As used in this section, "orthotic device" means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device.

(c) As used in this section, "prosthetic device" means an artificial leg or arm.

(d) As used in this section, "state employee health plan" means a:

(1) self-insurance program established under section 7(b) of this chapter; or

(2) contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter;

to provide group health coverage. The term does not include a dental or vision plan.

(e) A state employee health plan 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 covered individual's physician to be medically necessary to restore or maintain the covered individual's ability to perform activities of daily living or essential job related activities; and

(3) are not solely for comfort or convenience.

(f) The:

(1) coverage required under subsection (e) 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 subsection (e) 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 subsection does not require a deductible under a state employee health plan to be equal to a deductible under the federal Medicare program.

(g) Except as provided in subsections (h) and (i), the coverage required under subsection (e):

(1) may be subject to; and

(2) may not be more restrictive than;

the provisions that apply to other benefits under the state employee health plan.

(h) The coverage required under subsection (e) may be subject to utilization review, including periodic review, of the continued medical necessity of the benefit.

(i) 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 state employee health plan.

(j) For purposes of this subsection, "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 subsection (e) may not be subject to a deductible, copayment, or coinsurance provision that is less favorable to a covered individual than the deductible, copayment, or coinsurance provisions that apply to other items and services generally under the state employee health plan.

As added by P.L.109-2008, SEC.1.

IC 5-10-8-14.8

Employee health plan providing coverage for prescription eye drops

Sec. 14.8. (a) This section applies to an employee health plan that provides coverage for prescription eye drops.

(b) As used in this section, "covered individual" means an individual who is entitled to coverage under a state employee health plan.

(c) As used in this section, "state employee health plan" means one (1) of the following:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(d) A state employee health plan must provide coverage for a refill of prescription eye drops if the following are met:

(1) For a thirty (30) day supply, the covered individual requests the refill not earlier than twenty-five (25) days after the date the prescription eye drops were last dispensed to the covered individual.

(2) For a ninety (90) day supply, the covered individual requests the refill not earlier than seventy-five (75) days after the date the prescription eye drops were last dispensed to the covered individual.

(3) The prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested by the covered individual does not exceed the refillable amount remaining on the prescription.

(e) The coverage required by subsection (d) must not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to a covered individual than the dollar limits, copayments, deductibles, or coinsurance provisions that apply to coverage for prescription drugs generally under the state employee health plan.

(f) This section applies to a state employee health plan issued, delivered, amended, or renewed after December 31, 2015.

As added by P.L.43-2015, SEC.1.

IC 5-10-8-14.9

Coverage of methadone

Sec. 14.9. (a) This section applies to an employee health plan that is established, entered into, amended, or renewed after June 30, 2015.

(b) As used in this section, "state employee health plan" means one (1) of the following:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(c) A state employee health plan may provide coverage for methadone if the drug is prescribed for the treatment of pain or pain management as follows:

(1) If the daily dosage is not more than sixty (60) milligrams.

(2) If the daily dosage is more than sixty (60) milligrams, only if:

(A) prior authorization is obtained; and

(B) a determination of medical necessity has been shown by the provider.

As added by P.L.209-2015, SEC.1. Amended by P.L.149-2016, SEC.18.

IC 5-10-8-15

Coverage for care related to cancer clinical trials

Sec. 15. (a) As used in this section, "care method" means the use of a particular drug or device in a particular manner.

(b) As used in this section, "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.

(c) As used in this section, "covered individual" means an individual entitled to coverage under a state employee plan.

(d) As used in this section, "nonparticipating provider" means a health care provider that has not entered into a contract with a state employee plan to serve as a participating provider.

(e) As used in this section, "participating provider" means a health care provider that has entered into a contract with a state employee plan to provide health care services to covered individuals with an expectation of directly or indirectly receiving payment from the state employee plan.

(f) As used in this section, "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 state employee plan, including the sponsor of the clinical trial.

(g) As used in this section, "state employee plan" means one (1) of the following:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

(h) A state employee plan must provide coverage for routine care costs that are incurred in the course of a clinical trial if the state employee plan would provide coverage for the same routine care costs not incurred in a clinical trial.

(i) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the state employee plan, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers.

(j) This section does not do any of the following:

(1) Require a state employee plan to provide coverage for clinical trial services rendered by a participating provider.

(2) Prohibit a state employee plan from providing coverage for clinical trial services rendered by a participating provider.

(3) Require reimbursement under a state employee plan for services that are rendered in a clinical trial by a nonparticipating provider at the same rate of reimbursement that would apply to the same services rendered by a participating provider.

(k) This section does not create a cause of action against a person for any harm to a covered individual resulting from a clinical trial.
As added by P.L.109-2009, SEC.1.

IC 5-10-8-16
High breast density

Sec. 16. (a) As used in this section, "covered individual" means an individual who is entitled to coverage under a state employee health plan.

(b) As used in this section, "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.

(c) A state employee health plan must provide coverage for an appropriate medical screening, test, or examination for a female covered individual 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.1.

IC 5-10-8-17
Step therapy protocol

Sec. 17. (a) As used in this section, "covered individual" means an individual entitled to coverage under a state employee health plan.

(b) As used in this section, "preceding prescription drug" means

a prescription drug that, according to a step therapy protocol, must be:

(1) first used to treat a covered individual's condition; and

(2) as a result of the treatment under subdivision (1), determined to be inappropriate to treat the covered individual's condition;

as a condition of coverage under a state employee health plan for succeeding treatment with another prescription drug.

(c) As used in this section, "protocol exception" means a determination by a state employee health plan that, based on a review of a request for the determination and any supporting documentation:

(1) a step therapy protocol is not medically appropriate for treatment of a particular covered individual's condition; and

(2) the state employee health plan will:

(A) not require the covered individual's use of a preceding prescription drug under the step therapy protocol; and

(B) provide immediate coverage for another prescription drug that is prescribed for the covered individual.

(d) As used in this section, "state employee health plan" refers to the following that provide coverage for prescription drugs:

(1) A self-insurance program established under section 7(b) of this chapter.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

The term includes a person that administers prescription drug benefits on behalf of a state employee health plan.

(e) As used in this section, "step therapy protocol" means a protocol that specifies, as a condition of coverage under a state employee health plan, the order in which certain prescription drugs must be used to treat a covered individual's condition.

(f) As used in this section, "urgent care situation" means a covered individual's injury or condition about which the following apply:

(1) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could seriously jeopardize the covered individual's:

(A) life or health; or

(B) ability to regain maximum function;

based on a prudent layperson's judgment.

(2) If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a nonurgent situation, the injury or condition could subject the covered individual to severe pain that cannot be adequately managed, based on the covered individual's treating health care provider's judgment.

(g) A state employee health plan shall publish on the state employee health plan's Internet web site, and provide to a covered

individual in writing, a procedure for the covered individual's use in requesting a protocol exception. The procedure must include the following provisions:

(1) A description of the manner in which a covered individual may request a protocol exception.

(2) That the state employee health plan shall make a determination concerning a protocol exception request, or an appeal of a denial of a protocol exception request, not more than:

(A) in an urgent care situation, one (1) business day after receiving the request or appeal; or

(B) in a nonurgent care situation, three (3) business days after receiving the request or appeal.

(3) That a protocol exception will be granted if any of the following apply:

(A) A preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the covered individual.

(B) A preceding prescription drug is expected to be ineffective, based on both of the following:

(i) The known clinical characteristics of the covered individual.

(ii) Known characteristics of the preceding prescription drug, as found in sound clinical evidence.

(C) The covered individual has previously received:

(i) a preceding prescription drug; or

(ii) another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug;

and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the covered individual because the covered individual's use of the preceding prescription drug is expected to:

(i) cause a significant barrier to the covered individual's adherence to or compliance with the covered individual's plan of care;

(ii) worsen a comorbid condition of the covered individual; or

(iii) decrease the covered individual's ability to achieve or maintain reasonable functional ability in performing daily activities.

(4) That when a protocol exception is granted, the state employee health plan shall notify the covered individual and the covered individual's health care provider of the authorization for coverage of the prescription drug that is the subject of the

protocol exception.

(5) That if:

(A) a protocol exception request; or

(B) an appeal of a denied protocol exception request;

results in a denial of the protocol exception, the state employee health plan shall provide to the covered individual and the treating health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

(6) That the state employee health plan may request a copy of relevant documentation from the covered individual's medical record in support of a protocol exception.

As added by P.L.19-2016, SEC.1.

IC 5-10-8-18

Prescription drug coverage

Sec. 18. (a) The definitions in section 17 of this chapter apply throughout this section.

(b) This section applies to a state employee health plan that uses a formulary, cost sharing, or utilization review for prescription drug coverage.

(c) A state employee health plan shall not remove a prescription drug from the state employee health plan's formulary, change the cost sharing requirements that apply to a prescription drug, or change the utilization review requirements that apply to a prescription drug unless the state employee health plan does at least one (1) of the following:

(1) At least sixty (60) days before the removal or change is effective, send written notice of the removal or change to each covered individual for whom the prescription drug has been prescribed during the preceding twelve (12) month period.

(2) At the time a covered individual for whom the prescription drug has been prescribed during the preceding twelve (12) month period requests a refill of the prescription drug, provide to the covered individual:

(A) written notice of the removal or change; and

(B) a sixty (60) day supply of the prescription drug under the terms that applied before the removal or change.

As added by P.L.19-2016, SEC.2.