Form No: _____

Kentucky Department of Insurance

Health Product Review

Student Health* (Blanket) Checklist with Essential Health Benefits

(Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)

Statute/Rule	Description	Yes	No	Page #
General Requirements				
KRS 304.14-120 806 KAR 14:007 KRS 304.38-050	**Form Filing Requirements** – All policies must comply with the requirements of this statute and regulation for approval to be granted for use in Kentucky.			
KRS 304.17A-095 KRS 304.17A-0952	**Filing of Rates** – All health benefit plan policies must have a rate filing submitted in a separate filing and the rate filing must be approved prior to marketing of the product.			
KRS 304.18-020	**Group – Yes/No -** Does the group meet the definitions of one of the groups listed in this statute?			
KRS 304.18-030(1)	**Representations -** Statements are required to be representations not warranties.			
KRS 304.18-030(2)	**Benefits Summary -** A summary of benefits provided by the policy/certificate must be included.			
KRS 304.18-030(3)	**Additional Enrollees -** A provision to allow additional enrollees must be included.			
KRS 304.38-050	The contract & certificate must contain the following items: 1) A clear statement of the services to which the enrollee is entitled 2) A clear statement of any limitations on services, kinds of services or benefits, including deductibles and co-payments A clear statement telling the enrollee where & in what manner information is available as to how services may be obtained			
KRS 304.14-430	**Cover Page:** All insurance policies shall contain as the first page or first page of text a cover sheet or sheets as provided in this statute, • including a statement that the policy is the legal contract, • the "Read Your Policy Carefully" statement, • an index, • a brief summary of the extent and type of coverages in the policy.			
KRS 304.18-110	**Continuation -** All group health insurance is required to provide continuation of group coverage in accordance with the statute.			
KRS 304.18-114 806 KAR 17:260	**Conversion -** All group health insurance policies are required to provide for Conversion as outlined in this statute. **(The minimum benefits requirement of the regulation are pre-empted by ACA.)**			
KRS 304.18-040 806 KAR 18:020 Section 2	**Direct Provider Payment -** Payments may be made directly to the service provider instead of the insured. It may NOT require services be rendered by a particular provider.			
KRS 304.14-230(1)	**Electronic Delivery -** The policy/certificate may be delivered by electronic transfer, by agreement between the insurer and the insured or the person entitled to receive the policy/certificate.			
KRS 304.18-127	**Liability Transfer -** All group policies/certificates must comply with the requirements of transfer of liability in accordance with the statute.			
KRS 304.17A-702	**Clean Claims Payment** - For claims other than organ			

Statute/Rule	Description	Yes	No	Page #
806 KAR 17:360	transplants clean claims must be paid, denied or contested within 30 calendar days. Organ transplant claims must be paid within 60 calendar days.			
Bulletin 86-8	**COBRA -** All groups required to provide COBRA coverage must adhere to this Bulletin.			
KRS 304.17A-220(10)(c)	**Special Enrollment -** A group health plan must provide for a Special Enrollment period as outlined in this statue.			
KRS 304.17A-220(6)(d) and (e)	**Late Enrollee/Enrollment -** The definitions of late enrollee and late enrollment as used for KRS 304.17A-220 must meet the definitions as outlined in this statute.			
KRS 304.17A-220(6)(b)	**Enrollment Date -** There must be a definition for Enrollment date in accordance with this statute.			
KRS 304.17A-643(2) KRS 304.17A-641	**Continued Care** – All policies must contain a provision to allow continued care with a provider that is no longer participating in compliance with these statutes.			
KRS 304.17A-647(2)	**Access without Referral** – All policies must contain a provision that females are not required to get a referral for their annual gynecologist visit.			
KRS 304.17A-520	**Second Opinion** – All managed care plans shall provide access to a consultation with a participating provider for a second opinion			
KRS 304.17A-240(2)	**Guaranteed Renewal -** Except as provided in this section an insurer shall renew or continue in force a health benefit plan at the option of the insured.			
KRS 304.17A-240(3)	**Discontinuation -** If the insurer decides to discontinue offering a particular type of health benefit this section outlines the required notices.			
KRS 304.17A-250(7) KRS 304.18-085 806 KAR 18:030 KRS 304.38-185	**Coordination of Benefits -** All health benefit plans must coordinate benefits with other health benefit plans in accordance with this statutes and regulation.			
KRS 304.12-190 KRS 304.17A-245 806 KAR 17:010	**Refund of Unearned Premium –** All unearned premium must be refunded to the insurer/policyholder without limitation except for the reduction for claims paid.			
KRS 304.12-235 806 KAR 12:092	**Time of Payment of Claims-** All claims must be paid in thirty (30) days, after 30 days must pay interest on claim			
KRS 304.17A-243	**Grace Period** – All policies must contain a grace period of not less than 30 days.			
Grievance and Appeals				
KRS 304.17-412 KRS 304.38-225	**Utilization Review Requirements** – All insurers must comply with the statute if they provide for utilization review of benefits.			
KRS 304.17A-607 KRS 304.18-045	**UR Registration -** An insurer shall not provide or perform utilization reviews without being registered with the Department.			
	PLEASE PROVIDE NAME OF THE UR AGENT OR THIRD PARTY UR AGENT: **If using a 3rd party UR agent, verify that the licensed entity is listed as a client of the 3rd party's registration with the Department's Utilization Review Branch.**			
KRS 304.17A-617 Bulletin 2011-08	**Internal Appeal Disclosure -** Must disclose the availability of an internal appeal process.			
KRS 304.17A-623 Bulletin 2011-04	**External Appeal Disclosure -** Must disclose the availability of an external review of an adverse determination or coverage denial with a medical issue by an independent review entity			

	certified by the Department.			
KRS 304.17A-617(2)(a) and (b) KRS 304.17A-607(1)(i) 806 KAR 17:280	**Internal Appeal Timeframe -** Standard internal appeal decision must be provided within 30 calendar days or within 24 hours of receipt of claim/appeal but no greater than the maximum of 72 hours if additional information is needed for an expedited review decision			
KRS 304.17A-617(2) KRS 304.17A-623(3)	**External Appeal -** Guidelines for requesting an external review – four months			
KRS 304.17A-600(1) KRS 304.17A-617(1) Bulletin 2011-04	Definition of "adverse benefit determination" and Definition of "coverage denial"			
806 KAR 17:280 Section 4 806 KAR 17:290 Section 2 Bulletin 2011-08	**Appeal Instructions -** Instructions for requesting an oral (expedited) or written (non-expedited) appeal, including the position & telephone number of a contact person who can provide information relating to an internal or external appeal			
KRS 304.17A-625(5) KRS 304.17A-623(5) Bulletin 2011-04	**External Appeal Cost -** Notification that the insurer will be responsible for the cost of the external review; however, the covered person will be assessed a filing fee of $25, which may be waived in case of financial hardship or refunded if the external review decision favors the covered person.			
KRS 304.17A-623(4)	**Appeal Medical Authorization -** Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider			
KRS 304.17A-623(9)	**Confidentially for External Appeal -** A statement relating to the confidentiality of medical records and external review process.			
Kentucky Mandated Benefits				
KRS 304.18-032 KRS 304.17A-139 KRS 304.38-199 Advisory Opinion 2005-07	**Newborn -** Coverage for newborn children is required for the first 31 days. **Cannot require the newborn to meet deductible or charge premium for the first 31 days.** Notice of birth and premium payment may be required to continue coverage beyond the first 31 days.			
KRS 304.17A-140	**Adopted -** Coverage required the same for legally adopted children or any child for which the insured is a court-appointed guardian as a natural child.			
KRS 304.18-035	**Ambulatory Surgical Centers** – All policies providing coverage must provide coverage for healthcare treatment in an Ambulatory Surgical center.			
KRS 304.18-126(4)(a) Advisory Opinion 2010-03	**Extension of Benefits Hospital -** All group policies/certificates must provide a reasonable extension of benefits for hospital confinement when the group changes carriers in accordance with the statute.			
KRS 304.18-126(4)(b) Advisory Opinion 2010-03	**Extension of Benefits Disability -** All group policies/certificates must provide a reasonable extension of benefits for total disability when the group changes carriers in accordance with the statute.			
KRS 304.17A-005(23) KRS 304.18-095 KRS 304.18-097	**Health Care Provider/Provider Defined -** All health insurance policies must define doctor to include optometrists, osteopaths, physicians, chiropractors, and dentists.			
KRS 304.18-095 KRS 304.18-0363 KRS304.18-097 KRS 304.38-196 KRS 304.38-1933 KRS 304.38-195	**Payments for Certain Providers** – All policies must pay optometrists, osteopaths, physicians, chiropractors or podiatrists; for services for licensed psychologists or licensed clinical social workers; and services for dentists as outlined in these statutes.			

KRS 304.38-1955				
KRS 304.17A-505 KRS 304.17A-540	**Limitations/Exclusions -** Limits on coverage of any treatment, procedure, a drug, or devise shall be defined and fully disclosed in the policy and/or certificate.			
KRS 304.17A-098	**Rewards/Wellness Incentives –** Items outlined in this statute are not considered inappropriate inducement if disclosed in the policy; however, must make allowances for members with medical conditions, must be voluntary.			
KRS 304.17A-146	**Registered Nurse First Assistant Coverage –** If coverage for a surgical first assistant must also cover registered nurse first assistant			
KRS 304.17A-147 KRS 304.17A-1473	**Certified Surgical Assistant/Physician Assistant –** If a health plan covers surgical first assisting it must cover a certified surgical assistant or physician assistant.			
KRS 304.17A-149	**Dental Procedure Anesthesia –** All health benefit plans must cover anesthesia for dental procedures in accordance with this statute.			
KRS 304.17A-175	**Copayment for Chiropractor or Optometrist, –** Copayment or coinsurance for a chiropractor or optometrist must be no greater than the copayment or coinsurance of a physician or osteopath for the same or similar diagnosed conditions.			
KRS 304.17A-177 Advisory Opinion 2012-05	**Copayment for Occupational or Physical Therapist** – Copayment or coinsurance for a occupational or physical therapist must be no greater than the copayment or coinsurance of a physician or osteopathy for an office visit. **As stated in the Advisory Opinion the copayment/coinsurance cannot be greater than an office visit charge regardless of services provided or environment where services are rendered.**			
KRS 304.17A-254 KRS 304.17A-510 KRS 304.17A-590	**Provider Directories –** All health benefit plans that utilize a network of providers must provide upon request a current provider directory to insureds in accordance with these two statutes.			
KRS 304.17A-535 KRS 304.17A-505(j) 806 KAR 17:250	**Drug Formulary –** All health benefit plans that utilize a drug formulary must provide this listing to the insureds upon request, provide for a waiver program, limitations on generic substitution in accordance with this statute and regulation **The Drug Formulary Listing must also comply with Part 156.122 of the ACA.**			
KRS 304.17A-550	**Out of Network Benefits –** Managed care plans must offer a health benefit plan with out-of-network benefits in accordance with this statute.			
KRS 304.17A-647	**OB/GYN Access without Referral –** All health benefit plans cannot require a referral for annual pap.			
KRS 304.17A-645	**Referral from PCP limitation** – A PCP can make a referral for up to 12 months or for the contract period, whichever is shorter for a covered person with a chronic, disabling, congenital, or life threatening condition			
KRS 304.17A-166	**Prescription Eye Drop Coverage** – All health benefit plans must cover prescription eye drops in accordance with this statute, including providing an additional bottle every 3 months.			
KRS 304.17A-172	**Anti-Cancer Medications Coverage** – All health benefit plans that cover anti-cancer medications shall not require a higher copayment, deductible, or coinsurance amount than it requies for injected or intravenously administered anti-cancer medications. The health plan is deemed in compliance if they			

	do not impose a cost share of more than $100 per 30 day prescription.			
KRS 304.17A-168	**Tobacco Cessation Medications & Services** – All health benefit plans must provide coverage for all USFDA approved tobacco cessation medications recommended by the US Preventive Task Force including counseling and medications without a limitation on the attempts per benefit period and at no cost share. UR can be required after 2 attempts per benefit period.			
KRS 441.052	**Incarcerated Persons Coverage** – All policies must provide coverage for incarcerated persons who have NOT been convicted of a felony in accordance with this statute.			
ACA Requirements				
FORMULARY NAME:	**List the name of the formulary this product will utilize and provide the excel spreadsheet of the formulary to allow verification of drug counts.**	**Formulary Name:** _____		
	Lifetime Limits - No Lifetime Dollar Limits are allowed on Essential Health Benefits in a Health Benefit Plan.			
	Annual Limits - No Annual Dollar limits will be allowed on Essential Health Benefits in a Health Benefit Plan.			
	Out of Pocket Maximum – This cannot be greater than the following: 2017 Limits: $7,150 for self only coverage and $14,300 for other than self-only coverage. **2018 LIMITS: $7,350.00 for self-only coverage and $14,700 for other than self-only coverage.**			
	HSA PLAN DESIGNS – All services must accrue towards the deductible.			
	Rescission prohibition - Rescission is prohibited except for fraud or material misrepresentations			
	Dependent coverage - Dependents may be covered to age 26 without restrictions on marital, financial, or student status.			
	Grace Period – Policies offered through the Exchange to individuals receiving premium tax credit must have a grace period of 90 days.			
EFFECTIVE FOR PLANS ISSUED OR RENEWED AFTER 7/1/2016	**Schedules of Benefits** – The student health plans must have actuarial value of 60%. The schedules may have variability; however, the rate filing must indicate the minimum of each variable will meet the 60% actuarial value. A certification must be submitted with the form filing to indicate the actuarial value is in compliance.			
Essential Health Benefits				
Ambulatory patient services				
	Allergy testing and injections			
	High-dose chemotherapy for breast cancer			
	Office visit (primary care physician)			
	Office visit (specialist physician)			
	Outpatient facility fee			
	Outpatient surgery and facility fees			
	Sterilization Services for Males (Women's sterilization is covered in the Preventive Care section)			

	Reconstructive services to correct a deformity caused by disease, trauma, congenital anomalies or previous therapeutic process.			
Emergency Services				
KRS 304.17A-640	Must meet the definition in this statute and comply with the ACA definitions. • Cannot require prior authorization and • Cannot be limited to only services and care at participating providers;			
	Must be covered at **in-network cost-sharing level** (patient is not penalized for emergency care at out-of-network provider);			
	Must pay for out-of-network emergency services the greatest of: 1) the median in-network rate; 2) the usual customary & reasonable rate (or similar rate determined using the plan's or issuer's general formula for determining payments for out-of-network services); 3) the Medicare rate.			
KRS 304.17A-641(1)	"Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.			
	Ambulance Services - Both ground & air emergency ambulance must be provided at same cost-share for both in and out of network. Out of network may balance bill. - Non-emergency ambulance must be covered in-network as outlined in the 2017 Kentucky Benchmark			
Hospitalization				
	Inpatient facility services, including physical medicine and rehabilitation.			
	Surgical services, including anesthesia			
	Reconstructive services to correct a deformity caused by disease, trauma, congenital anomalies or previous therapeutic process.			
Maternity Coverage				
KRS 304.17A-145	Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section.			
	No prior authorization required for 48/96 hour hospital stay.			
	Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital.			
	Services following a miscarriage			
	Services include physician care for a normal or complicated pregnancy			
	Obstetrical care through the end of the pregnancy and the immediate post-partum period.			
	Services cannot be limited based on the location of the labor and delivery			
KRS 304.18-033	**Nursery Care –** An offer to purchase coverage for routine nursery care for up to 5 days – N/A if routine nursery care is in the contract.			
Mental health and substance use disorder services, including behavioral health treatment				
KRS 304.18-036 KRS 304.18-130	Inpatient behavioral health services must be in parity to sickness/illness coverage.			
KRS 304.18-150 KRS 304.18-160	Outpatient behavioral health services must be in parity to sickness/illness coverage.			
KRS 304-18-170 KRS 304.17A-661*	Inpatient mental health and substance abuse must be in parity to sickness/illness coverage.			
	Outpatient mental health and substance abuse must be in parity to			

	sickness/illness coverage. ***The reference to this site is give guidance on what the Department considers "parity" or "to the same extent and degree as coverage provided by the policy or contract for the treatment of physical illnesses."**			
Prescription Drugs				
	The prescription drug benefit must cover at least "One drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB-benchmark plan". **Must contain an exception policy in compliance with ACA regulations, including timeframes.** **Must comply with the Drug Formulary listing requirement of Part 156.122(d)(1) of the ACA.**			
	Mail-Order Opt Out provision – must allow members to opt-out of the required mail order provision allowing the member to get medications at a retail pharmacy.			
KRS 304.17A-148	Certain supplies & equipment for diabetes and asthma (may have in-network requirements)			
KRS 304.17A-258	Therapeutic food, formulas, supplements, & low-protein modified food products for inborn error of metabolism & genetic conditions (prior authorization requirements)			
KRS 304.17A-139	**Milk Fortifier** – 100% Human Diet – all health benefit plans must provide coverage for 100% human diet as outlined in this statute.			
KRS 304.17A-163 **KRS 304.17A-535** **806 KAR 17:250** **KRS 304.17A-165**	**Step Therapy Override** - All health benefit plans must have an override of restrictions on medication sequence in step therapy or fail-first protocol			
Habilitative services				
	The Habilitative coverages must be in compliance with the ACA definition of Habilitation Services. Please review the coverages and exclusions in the policy to ensure coverage is not in conflict with the ACA requirements.			
	Physical Therapy – must cover a minimum of 25 visits			
	Occupational Therapy – must cover a minimum of 25 visits			
	Speech Therapy – must cover a minimum of 25 visits			
Rehabilitative services and devices				
	Physical Therapy – must cover a minimum of 25 visits			
	Occupational Therapy – must cover a minimum of 25 visits			
	Speech Therapy – must cover a minimum of 25 visits			
	Pulmonary Rehabilitation – must cover a minimum of 25 visits			
	Cardiac Rehabilitation – must cover a minimum of 36 visits			
	Manipulation Therapy – must cover a minimum of 20 visits			
	Post-Cochlear Implant Aural Therapy – must cover a minimum of 30 visits.			
	Cognitive Rehabilitation Therapy – must cover a minimum of 20 visits.			
	Durable Medical Equipment, **Medical Supplies and Appliances**			
	Orthotic devises			

Laboratory services				
	Complex imaging services			
	Outpatient laboratory services			
	Outpatient x-ray services			
	Allergy Tests			
Other				
	Private-Duty Nursing – must cover at least 250-eight hour visits per year			
KRS 304.18-037	**Home Health Care Services –** must cover at least 100 visits per year. The minimum to be considered a visit is four (4) hours. **[preempts KY mandate]**			
	Skilled Nursing Facility – must cover at least 90 days per year			
KRS 304.17A-132	**Hearing Aids** – one hearing aid per affected ear once every 36 months **[preempts KY mandate]**			
KRS 304.17A-141 KRS 304.17A-143 806 KAR 17:460 Advisory Opinion 2012-04	**Autism Spectrum Disorder** must cover as outlined in the 2017 Kentucky Benchmark **[Preempts KY mandate]**			
806 KAR 17:490 KRS 304.17A-250(6) Advisory Opinion 2014-04	**Hospice** - All health benefit plans must cover Hospice at least equal to Medicare benefits. **Cannot apply deductible unless the plan design is a High Deductible Health Plan with an HSA.** **Must provide same coverage in and out of network at same cost share. HMO plan designs must indicate on the schedule that the member has out-of-network coverage.**			
Preventive and wellness services				
	Preventive Services - Preventive services must be provided without cost sharing (no – co-payments, co-insurance or deductibles apply)– including the following:			
	Services recommended by the US Preventive Services Task Force with a rating of A or B **Check exclusions for conflicts with the recommendations.**			
	Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC **Check exclusions for conflicts with the recommendations.**			
	Preventive care & screenings for infants, children, & adolescents supported by the Health Resources & Services Administration **Check exclusions for conflict with the recommendations.**			
KRS 304.17A-135 KRS 304.17A-133 KRS 304.38-1935	Women's Preventive Care and Screenings including contraceptives, breast feeding support, sterilization procedures. **Check exclusions for conflict with the recommendations.**			
KRS 304.18-098	**Expanded Mammography** - Expanded mammogram coverage required for insureds of any age with a diagnosis of breast cancer must be included.			
KRS 304.17A-257	**Colorectal** - Coverage for colorectal cancer examinations and			

	laboratory tests specified in current American Cancer Society guidelines – **At no cost share.**			
Chronic Disease management and pediatric services, including oral and vision care				
KRS 304.17A-131	**Cochlear** - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.			
KRS 304.18-0983 KRS 304.17A-134 KRS 304.38-1936	**Mastectomy/Endometrioses/Endometritis/Bone Density Testing** -For expense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of endometrioses and endometritis and bone density testing as outlined in the statute. Mastectomy coverage cannot be required to be on an outpatient basis.			
KRS 304.17A-136	**Cancer Clinical Trials coverage** – Health benefit plans cannot exclude coverage for routine patient healthcare costs that are incurred in the course of a cancer clinical trial as outlined in this statute.			
KRS 304.17A-148	**Diabetes** - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.			
KRS 304.17A-135 KRS 304.18-0985 KRS 304.38-1936	**Breast Cancer** - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.			
KRS 304.18-0365 806 KAR 17:090 KRS 304.38-1937	**TMJ** - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular jaw disorders must be provided in accordance with the statute.			
2017 Kentucky Benchmark	**Pediatric Dental Services** (See 2017 Kentucky Benchmark Dental Checklist for specific benefits) **Coverage must be provided through the end of the month the member turns 21.**			
2017 Kentucky Benchmark	**Pediatric Vision Services** (See 2017 Kentucky Benchmark for specific benefits) ▪ Be limited to a recipient who is under age twenty-one (21) ▪ Must not exclude vision training and orthoptics ▪ One routine vision examination or refraction only in lieu of a complete exam per year ▪ One complete set of eyeglass frames and lenses per year, with one complete replacement set if medically necessary per year ▪ **One contact lens fitting and evaluation per year** ▪ One set of contacts per year (or the yearly equivalent) ▪ Only required to cover either eyeglasses or contacts not both. **Coverage must be provided through the end of the month the member turns 21.**			
Prohibited Provisions				
KRS 304.5-160	**Abortion** - Health insurance contracts cannot cover abortion except by rider except by an optional rider for which there must be paid an additional premium			
KRS 304.12-013(5)(a)	**AIDS/HIV** - Health insurance policies/certificates may not limit,			

& (b)	reduce or exclude AIDS related benefits			
KRS 417.050	**Arbitration** – Insurance contracts cannot contain arbitration clauses.			
KRS 304.12-250	**Work-Related Exclusion** - Health insurance policies/certificate cannot exclude work-related conditions unless the claimant is eligible for benefits under any workers' compensation.			
KRS 304.14-170	**Charter/By-laws** - The charter, bylaws or other constituent documents of the insurer should not be included in the policy (Does not apply to Fraternal Benefit Society filings.)			
KRS 304.17A-155 **KRS 304.12-211**	**Domestic Violence** – Cannot deny coverage, refuse to issue or renew, cancel or otherwise terminate, restrict, or exclude any person from a health benefit plan on the basis the person is a victim of domestic violence and abuse.			
KRS 304.14-370 **KRS 304.14-380**	**Jurisdiction of Courts/Venue of Suits** – All policies must comply with this statute.			
KRS 304.17A-138 **806 KAR 17:270**	**Telehealth Exclusion** - A Health Benefit Plan shall not exclude a service from coverage solely because the service is provided through Telehealth services.			
806 KAR 18:020	**25% Differential for Non-HMO companies -** Health insurers cannot offer contracts containing preferred provider arrangements where the difference between amounts payable for preferred provider and a non-preferred provider exceed 25 percent. The Department's position on compliance with this regulation is the difference between copayments/coinsurances the member pays for out of network providers/services versus in-network providers/services is not greater than 25%. **If a non-HMO licensed entity offered a service as a in-network benefit there must be a corresponding out-of-network benefit.** Provider directories and plan information must be provided upon request.			
806 KAR 17:050	**Medicaid Eligibility** – Coverage cannot be limited, canceled, or deny coverage because a proposed insured is eligible for Medicaid			
Advisory Opinion 2010-01	**Discretionary Clauses** - The Department does not allow Discretionary Clauses in insurance policies.			

***Licensed Health Maintenance Organizations (HMO) must comply with all of the KRS 304.38 code site references. Non-HMO licensed entities do not have to comply with KRS 304.38 code site references.**