Form No: _____

Kentucky Department of Insurance

Health Product Review

NON-GRANDFATHERED LARGE GROUP HEALTH BENEFIT PLAN* (MAJOR MEDICAL COVERAGE) CHECKLIST

(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 individual 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-**			

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Statute/Rule	Description	Yes	No	Page #
	empted by ACA.)			
KRS 304.18-040 806 KAR 18:020	**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-702 806 KAR 17:360	**Clean Claims Payment -** For claims other than organ 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 these 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 KRS 304.17A-702 KRS 304.17A-730	**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.			

NON-GRANDFATHERED LARGE GROUP HEALTH BENEFIT PLAN (MAJOR MEDICAL COVERAGE) CHECKLIST (continued)

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Statute/Rule	Description	Yes	No	Page #
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 UR AGENT OR THIRD PARTY 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 as outlined in these sites (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	**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			

NON-GRANDFATHERED LARGE GROUP HEALTH BENEFIT PLAN (MAJOR MEDICAL COVERAGE) CHECKLIST (continued)

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Statute/Rule	Description	Yes	No	Page #
	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 KRS 304.38-1955	**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 304.17A-505 RS 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 an occupational or physical therapist must be no greater than the copayment or coinsurance of a physician or osteopath 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			
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			

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	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 benefits 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 requires for injected or intravenously administered antic-cancer medications. The health plan is deemed in compliance if they do not impost 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.			
PPACA Requirements				
NETWORK NAME:	**List the name of the network this product will utilize and whether this network has been approved.**	**NETWORK NAME:** _____ **Approved Date:** ☐		
	Lifetime Limits - No Lifetime Dollar Limits are allowed to be on Essential Health Benefits in a Health Benefit Plan.			
	HSA PLAN DESIGNS – All services must accrue towards the deductible.			
	Out of Pocket Maximum –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 $14,700.00 for other than self-only coverage.** **FOR HSA-qualified High Deductible Health Plans – Maximum:** 2017 Limits: $6550 for self-only coverage and $13,100 for other than self-only coverage. **2018 LIMITS: = $6,650 for self-only coverage and $13,300 for other than self-only coverage.**			
	Rescission prohibition - Rescission is prohibited except for fraud or material misrepresentations			
KRS 304.17A-256 **KRS 304.17A-140**	**Dependent coverage -** Dependents may be covered to age 26 without restrictions on marital, financial, or student status.			
KRS 304.17A-640 **KRS 304.17A-641(1)**	**Emergency Room Coverage** – Must provide coverage for emergency room visits in accordance with these statutes.			
KRS 304.17A-145	**Maternity Coverage –** coverage, if offered, must meet the requirements of these statutes. If the group is larger than 8 it must provide maternity.			

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Statute/Rule	Description	Yes	No	Page #
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.			
KRS 304.18-036 KRS 304.18-130 KRS 304.18-150 KRS 304.18-160 KRS 304-18-170 KRS 304.17A-661*	**Mental Health Parity** – All mental health services must be offered and if offered, must meet mental health parity requirements. **Alcoholism Coverage** – must be offered and if offered, must meet the requirements of these statutes. *The reference to this site is to 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."			
KRS 304.17A-148	**Diabetes** – Coverage for diabetes must be provided as outlined in this statute.			
KRS 304.17A-258	**Therapeutic Food/PKU –** 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			
KRS 304.18-037 KRS 304.38-210	**Home Health Care Services –** if offered, must cover at least 60 visits per year.			
KRS 304.17A-132	**Hearing Aids** – must provide coverage up one for individuals under 18 every 36 months **($1,400 limit Preempted by PPACA – No annual dollar limits on EHB)**			
KRS 304.17A-141 KRS 304.17A-143 806 KAR 17:460 Advisory Opinion 2012-04	**Autism Spectrum Disorder** – coverage is for 1 through 21 year olds. Age 1 through 7 is $50,000 annual benefit – age 7 through 21 is $1,000 per month. **(Dollar limits preempted by PPACA – no annual dollar limits on EHB)**			
806 KAR 17:490 KRS 304.17A-250(6)	**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.**			
KRS 304.17A-135 KRS 304.17A-133 KRS 304.38-1935 KRS 304.17-316	**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.			

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Statute/Rule	Description	Yes	No	Page #
	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 conflicts with the recommendations.			
	Women's Preventive Care and Screenings including contraceptives, breast feeding support, sterilization procedures. Check exclusions for conflicts 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 **EFFECTIVE: 01-01-2016 – At no cost share**			
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-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.			
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) & (b)	**AIDS/HIV** - Health insurance policies/certificates may not limit, 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.)			

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Statute/Rule	Description	Yes	No	Page #
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. Provider directories and plan information must be provided upon request. 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 services as a in-network benefit there must be a corresponding out of network benefit.**			
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.**