Kentucky Department of Insurance

BASIC HEALTH BENEFIT PLAN SUMMARY SHEET – FORM AND RATE FILINGS

1. Company name: ____ NAIC#______________
   (Name listed on the certification of authority and/or articles of incorporation)

D/B/A:____
(Name listed on the field certificate of assumed name)

2. Policy form number(s):____

3. Company filing number (if applicable):______________________________________

4. Product name:____

5. Product type: FFS PPO POS HMO

6. PPO or POS plan requires out-of-network referral: Yes No

7. Market segment: Small Group Employer Organized Association Individual

8. Product includes a minimum loss ratio guarantee benefit: Yes No

9. If applicable, please check if this filing is:

   A. A product for sale with a health savings account ( )

   B. A conversion policy ( )

10. Please check the optional state mandated benefits that will be covered under this basic health benefit plan:

    A. Coverage of amino acid modified preparations and low-protein modified food products for the treatment of inborn errors of metabolism and genetic conditions required under KRS 304.17A-258(2) ( )

    B. Coverage of the treatment of temporomandibular and craniomandibular jaw disorders required under KRS 304.17-319, 304.18-0365, 304.32-1585, 304.38-1937, and 806 KAR 17:090 ( )

    C. Coverage of the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation required under KRS 304.17-3165, 304.17A-135, 304.18-0985, 304.32-1595, and 304.38-1936 ( )

    D. Coverage of the treatment of human immunodeficiency virus infections required under KRS 304.12-013(5) ( )

    E. Coverage of cochlear implants required under KRS 304.17A-131 ( )

F.	Coverage of the treatment of autism in children required under KRS 304.17A-143 and 806 KAR 17:460	( )
G.	Coverage of telehealth services required under KRS 304.17A-138 and 806 KAR 17:270	( )
H.	Coverage of anesthesia and hospital or facility charges in connection with dental procedures required under KRS 304.17A-149 and 806 KAR 17:095	( )
I.	Coverage of hearing aids and related services required under KRS 304.17A-132	( )
J.	Coverage for dependents required under KRS 304.17-310(1) & (2)	( )
K.	Coverage of a second opinion required under KRS 304.17A-520(4)	( )

11. Are any of the benefits listed in item #10 covered in part: Yes No

12. If "Yes" was indicated in item #11, attach a description of each benefit covered in part.

Completed by:____ Date: ______________

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