

Kentucky Department of Insurance

Health Product Review

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

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.			
<u>KRS 304.18-020</u>	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.			
<u>KRS 304.18-030(3)</u>	Additional Enrollees - A provision to allow additional enrollees must be included.			
<u>KRS 304.38-050</u>	 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 copayments A clear statement telling the enrollee where & in what manner information is available as to how services may be obtained 			
<u>KRS 304.14-430</u>	 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-			

Statute/Rule	t must be submitted with filing – attach as a PDF if filing ele Description	Yes	No	Page #
Statute/ Nule	empted by ACA.)	105	110	1 agt #
KRS 304.18-040	Direct Provider Payment - Payments may be made directly to		+	
806 KAR 18:020	the service provider instead of the insured. It may NOT			
000 11111 10.020	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			
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.			
<u>KRS 304.17A-</u>	Special Enrollment - A group health plan must provide for a			
<u>220(10)(c)</u>	Special Enrollment period as outlined in this statue.			
KRS 304.17A-220(6)(d)	Late Enrollee/Enrollment - The definitions of late enrollee			
and (e)	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.			
<u>KRS 304.17A-643(2)</u> KDS 204.17A (41	Continued Care – All policies must contain a provision to			
KRS 304.17A-641	allow continued care with a provider that is no longer			
VDS 204 174 (47(2)	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			
<u>KKS 504.17A-520</u>	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)	Coordination of Benefits - All health benefit plans must			
KRS 304.18-085	coordinate benefits with other health benefit plans in			
806 KAR 18:030	accordance with these statutes and regulation.			
<u>KRS 304.38-185</u>				
<u>KRS 304.12-190</u>	Refund of Unearned Premium – All unearned premium must			
KRS 304.17A-245	be refunded to the insurer/policyholder without limitation			
806 KAR 17:010	except for the reduction for claims paid.			
KRS 304.12-235	Time of Payment of Claims- All claims must be paid in thirty			
806 KAR 12:092	(30) days, after 30 days must pay interest on claim			
<u>KRS 304.17A-243</u>	Grace Period – All policies must contain a grace period of not			
	less than 30 days. HSA PLAN DESIGNS – All services must accrue towards the			
	HSA PLAN DESIGNS – All services must accrue towards the deductible.			
Grievance and Appeals		1		
KRS 304.17-412	Utilization Review Requirements – All insurers must comply			
KRS 304.17-412 KRS 304.38-225	with the statute if they provide for utilization review of			
<u>IXINO JUH.JO-443</u>	benefits.			
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KRS 304.17A-607 UR Registration - An insurer shall not provide or perform utilization reviews without being registered with the Department. Utilization Review Agent: KRS 304.17A-617 Internal Appeal Disclosure - Must disclose the availability of Bulletin 2011-08 Internal Appeal Disclosure - Must disclose the availability of Bulletin 2011-04 Res 304.17A-623 External Appeal Disclosure - Must disclose the availability of Bulletin 2011-04 Internal Appeal Disclosure - Must disclose the availability of Bulletin 2011-04 Res 304.17A-623 External Appeal Timeframe - Standard internal appeal decision must be provided as outlined in these sites (within 30 Bol KAR 17:280 calendar days or maximum of 72 hours for an expedied review decision) KRS 304.17A-617(2) External Appeal - Guidelines for requesting an external review decision) review - four months KRS 304.17A-617(2) KRS 304.17A-617(2) "coverage denial" 806 KAR 17:280 Appeal Instructions for requesting an oral (expedited) or written (non-expedited) appeal, including the 306 KAR 17:280 Spotion & Ciephone number of a contact eprson who can provide information relating to an internal or external appeal 806 KAR 17:280 External Appeal Cost - Notification that the insurer will be (ex30 with Max 4633) or erfundability or for the contidentiality or four the insure is any provide information relating to an internal or external appeal 806 KAR 17:280 External Appeal Cost - Notification that the insure will be (ex30 with (A + 6335))	Statute/Rule	t must be submitted with filing – attach as a PDF if filing ele Description	Yes	No	Page #
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carriers in accordance with the statute.		1 1			
KRS 304.18-126(4)(b) Extension of Benefits Disability - All group	KRS 304.18-126(4)(b)	Extension of Benefits Disability - All group			
Advisory Opinion policies/certificates must provide a reasonable extension of					
2010-03 benefits for total disability when the group changes carriers in					
accordance with the statute.					
KRS 304.17A-005(23) Health Care Provider/Provider Defined - All health	KRS 304.17A-005(23)	Health Care Provider/Provider Defined - All health			
KRS 304.18-095 insurance policies must define doctor to include optometrists,		insurance policies must define doctor to include optometrists,			
KRS 304.18-097 osteopaths, physicians, chiropractors, and dentists.	KRS 304.18-097	osteopaths, physicians, chiropractors, and dentists.			
KRS 304.18-095 Payments for Certain Providers – All policies must pay	KRS 304.18-095	Payments for Certain Providers - All policies must pay			

-	st must be submitted with filing – attach as a PDF if filing ele			•
Statute/Rule	Description	Yes	No	Page #
KRS 304.18-0363	optometrists, osteopaths, physicians, chiropractors or			
KRS304.18-097	podiatrists; for services for licensed psychologists or licensed			
KRS 304.38-196	clinical social workers; and services for dentists as outlined in			
KRS 304.38-1933	these statutes.			
KRS 304.38-195				
KRS 304.38-1955				
KRS 304.17A-505	Limitations/Exclusions - Limits on coverage of any treatment,			
<u>RS 304.17A-540</u>	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	Certified Surgical Assistant/Physician Assistant – If a health			
KRS 304.17A-1473	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, Optometrist, Occupational			
KRS 304.17A-177	or Physical Therapist – Copayment or coinsurance for a			
	chiropractor, optometrist, occupational or physical therapist			
	must be no greater than the copayment or coinsurance of a			
	physician or osteopath			
KRS 304.17A-254	Provider Directories – All health benefit plans that utilize a			
KRS 304.17A-510	network of providers must provide upon request a current			
KRS 304.17A-590	provider directory to insureds in accordance with these two			
	statutes.			
KRS 304.17A-535	Drug Formulary – All health benefit plans that utilize a drug			
KRS 304.17A-505(j)	formulary must provide this listing to the insureds upon			
806 KAR 17:250	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.			
<u>KRS 304.17A-645</u>	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,			
VDC 441 050	congenital, or life threatening condition			
<u>KRS 441.052</u>	Incarcerated Persons Coverage – All policies must provide			
	coverage for incarcerated persons who have NOT been			
ZDC 204 154 254	convicted of a felony in accordance with this statute.			
KRS 304.17A-256 KRS 304.17A 140	Dependent coverage - Dependents may be covered to age 26 without matrixitians on marital financial or student status			
KRS 304.17A-140	without restrictions on marital, financial, or student status.			
KRS 304.17A-640	Emergency Room Coverage – Must provide coverage for			
<u>KRS 304.17A-641(1)</u>	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 Nursery Care – An offer to purchase coverage for routine	Yes	No	Page #
<u>KRS 304.18-033</u>	Nursery Care – An other 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	Mental Health Parity – All mental health services must be			
KRS 304.18-130	offered and if offered, must meet mental health parity			
KRS 304.18-150	requirements.			
KRS 304.18-160	requirements.			
KRS 304-18-170	Alcoholism Coverage – must be offered and if offered, must			
KRS 304.17A-661	meet the requirements of these statutes.			
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-163	Step Therapy Override - All health benefit plans must have			
KRS 304.17A-535	an override of restrictions on medication sequence in step			
806 KAR 17:250	therapy or fail-first protocol			
KRS 304.17A-165				
KRS 304.18-037	Home Health Care Services – if offered, must cover at least			
KRS 304.38-210	60 visits per year.			
KRS 304.17A-132	Hearing Aids – must provide coverage one for individuals			
KK5 504.17A-152	under 18 every 36 months			
	under 16 every 56 monuls			
KRS 304.17A-141	Autism Spectrum Disorder – coverage is for 1 through 21		$\left \right $	
KRS 304.17A-141 KRS 304.17A-143	year olds. Age 1 through 7 is \$50,000 annual benefit – age 7			
806 KAR 17:460	through 21 is \$1,000 per month			
000 IXAX 17.400	ullough 21 is \$1,000 per month			
806 KAR 17:490	Hospice - All health benefit plans must cover Hospice at least			
KRS 304.17A-250(6)	equal to Medicare benefits with the exception of HSAs.			
1310304.17A-230(0)	equal to Medicale benefits with the exception of HSAS.			
KRS 304.17A-133	Mammography – All expense incurred health insurance			
KRS 304.38-1935	policies must cover mammograms in accordance with this			
KRS 304.17-316	statute.			
<u>IXIX) 504.17-510</u>	Suture.			
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	Mastectomy/Endometrioses/Endometritis/Bone Density			
KRS 304.17A-134	Testing -For expense-incurred policies must provide coverage			
KRS 304.38-1936	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			
KDS 204 174 126	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.			
	outined in this statute.	L	I	

	st must be submitted with filing – attach as a PDF if filing ele	Yes	No	
Statute/Rule	Description Breast Cancer - The mandated coverage for the treatment of	res	INO	Page #
KRS 304.17A-135 KRS 304 18 0085	breast cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.			
KRS 304.18-0985 KRS 304.38-1936	breast cancer must be provided in accordance with the statute.			
	TMI The mondeted equations for treatment of			
KRS 304.18-0365 806 KAR 17:090	TMJ - The mandated coverage for treatment of			
	Temporomandibular joint disorders (TMJ) and			
<u>KRS 304.38-1937</u>	craniomandibular jaw disorders must be provided in			
KDC 204 474 472	accordance with the statute. Anti-Cancer Medications Coverage – All health benefit plans			
KRS 304.17A-172	that cover 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			
KK3 304.17A-108	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.			
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			
<u>& (b)</u>	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.)			
KRS 304.17A-155	Domestic Violence – Cannot deny coverage, refuse to issue or			
KRS 304.12-211	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	Jurisdiction of Courts/Venue of Suits – All policies must			
KRS 304.14-380	comply with this statute.			
KRS 304.17A-138	Telehealth Exclusion - A Health Benefit Plan shall not			
806 KAR 17:270	exclude a service from coverage solely because the service is			
206 VAD 10.020	provided through Telehealth services.25% Differential for Non-HMO companies - Health insurers		$\left - \right $	
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.			
806 KAR 17:050	Medicaid Eligibility – Coverage cannot be limited, canceled,			
000 IXAN 17.030	or deny coverage because a proposed insured is eligible for			
	Medicaid			
Advisory Opinion	Discretionary Clauses - The Department does not allow			
<u>2010-01</u>	Discretionary Clauses in insurance policies.			
	,,,	1		

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

*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.