



# **Kentucky Department of Insurance**

Health Product Review

### NON-GRANDFATHERED SMALL GROUP HEALTH BENEFIT PLAN\* (MAJOR MEDICAL COVERAGE) CHECKLIST with Essential Health Benefits

Statute/Rule	Description	Yes	No	Page #
<b>General Requirem</b>	ents			
KRS 304.14-120 806 KAR 14:007 KRS 304.38-050	<b>Form Filing Requirements</b> – 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	<b>Filing of Rates</b> – 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	<b>Group</b> – <b>Yes/No</b> - Does the group meet the definitions of one of the groups listed in this statute?			
<u>KRS 304.18-</u> <u>030(1)</u>	<b>Representations -</b> Statements are required to be representations not warranties.			
<u>KRS 304.18-</u> <u>030(2)</u>	<b>Benefits Summary -</b> A summary of benefits provided by the policy/certificate must be included.			
<u>KRS 304.18-</u> 030(3) KRS 304.38-050	Additional Enrollees - A provision to allow additional enrollees         must be included.         The contract & certificate must contain the following items:			
	<ol> <li>A clear statement of the services to which the enrollee is entitled</li> <li>A clear statement of any limitations on services, kinds of services or benefits, including deductibles and co- payments</li> </ol>			
	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>	<ul> <li>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,</li> <li>including a statement that the policy is the legal contract,</li> <li>the "Read Your Policy Carefully" statement,</li> <li>an index,</li> </ul>			
	• a brief summary of the extent and type of coverages in the policy.			
<u>KRS 304.18-110</u>	<b>Continuation -</b> 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	<b>Conversion -</b> All group health insurance policies are required to provide for Conversion as outlined in this statute. ( <b>The minimum</b> <b>benefits requirement of the regulation are pre-empted by</b> <b>ACA.</b> )			
KRS 304.18-040 806 KAR 18:020	<b>Direct Provider Payment -</b> Payments may be made directly to the service provider instead of the insured. It may NOT require			

Statute/Rule	(Checklist must be submitted with filing – attach as a PDF if filing electronic Description	Yes	No	Page #
Section 2	services be rendered by a particular provider.	105	110	I uge //
<u>KRS 304.14-</u>	<b>Electronic Delivery -</b> The policy/certificate may be delivered by			
<u>230(1)</u>	electronic transfer, by agreement between the insurer and the			
<b>VDC 204 10 105</b>	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			
VDC 204 174	statute.			
KRS 304.17A- 702	<b>Clean Claims Payment -</b> For claims other than organ transplants			
702 806 KAR 17:360	clean claims must be paid, denied or contested within 30 calendar days. Organ transplant claims must be paid within 60 calendar			
<u>000 KAK 17:500</u>	days. Organ transplant claims must be paid within 60 calendar days.			
Bulletin 86-8	<b>COBRA</b> - All groups required to provide COBRA coverage must			
Dunetin 80-8	adhere to this Bulletin.			
KRS 304.17A-	Special Enrollment - A group health plan must provide for a			
<u>220(10)(c)</u>	Special Enrollment - A group heatin plan must provide for a Special Enrollment period as outlined in this statue.			
<u>KRS 304.17A-</u>	Late Enrollee/Enrollment - The definitions of late enrollee and			
$\frac{1}{220(6)(d)}$ and (e)	late enrollment as used for KRS 304.17A-220 must meet the			
	definitions as outlined in this statute.			
KRS 304.17A-	<b>Enrollment Date -</b> There must be a definition for Enrollment date			
<u>220(6)(b)</u>	in accordance with this statute.			
KRS 304.17A-	<b>Continued Care</b> – All policies must contain a provision to allow			
643(2)	continued care with a provider that is no longer participating in			
KRS 304.17A-	compliance with these statutes.			
641	1			
KRS 304.17A-	Access without Referral – All policies must contain a provision			
647(2)	that females are not required to get a referral for their annual			
	gynecologist visit.			
KRS 304.17A-	Second Opinion – All managed care plans shall provide access to			
<u>520</u>	a consultation with a participating provider for a second opinion.			
KRS 304.17A-	Guaranteed Renewal - Except as provided in this section an			
<u>240(2)</u>	insurer shall renew or continue in force a health benefit plan at the			
	option of the insured.			
KRS 304.17A-	<b>Discontinuation</b> - If the insurer decides to discontinue offering a			
<u>240(3)</u>	particular type of health benefit this section outlines the required			
	notices.			
<u>KRS 304.17A-</u>	Coordination of Benefits - All health benefit plans must			
<u>250(7)</u>	coordinate benefits with other health benefit plans in accordance			
KRS 304.18-085	with this statutes and regulation.			
806 KAR 18:030				
<u>KRS 304.38-185</u> KRS 204 12 100	<b>Refund of Unearned Premium</b> – All unearned premium must be			
KRS 304.12-190 KRS 304.17A-	refunded to the insurer/policyholder without limitation except for			
<u>245</u>	the reduction for claims paid.			
<u>806 KAR 17:010</u>	the reduction for claims paid.			
KRS 304.12-235	<b>Time of Payment of Claims-</b> All claims must be paid in thirty (30)			
806 KAR 12:092	days, after 30 days must pay interest on claim.			
KRS 304.17A-	,.,.,			
702				
KRS 304.17A-				
730				
KRS 304.17A-	Grace Period – All policies must contain a grace period of not less			
243	than 30 days.			
Grievance and Ap	peals			
KRS 304.17-412	Utilization Review Requirements – All insurers must comply			
KRS 304.38-225	with the statute if they provide for utilization review of benefits.			
KRS 304.17A-	UR Registration - An insurer shall not provide or perform			
			I	

diff       utilization reviews without being registered with the Department.         CRS 304.18-045       PLEASE PROVIDE NAME OF UR AGENT OR THIRD PARTY AGENT:         If       using a 3 <sup>rd</sup> party UR agent, verify that the licensed entity is listed as a client of the 3 <sup>rd</sup> party's registration with the Department's Utilization Review Branch.         Thermal Appeal Disclosure - Must disclose the availability of an internal appeal process.       Internal 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.         Thermal Appeal Timeframe - Standard internal appeal decision friz(2)(a) and (b).       Thermal Appeal Timeframe - Standard internal appeal decision friz(2)(a) and (b).         RES 304.17A.       External Appeal Timeframe - Standard internal appeal decision friz(2)(a) and (b).         RES 304.17A.       External Appeal - Guidelines for requesting an external review - four months.         GRS 304.17A.       Definition of "adverse benefit determination" and Definition of "coverage denial".         GRS 304.17A.       Definition of "adverse benefit determination" and Definition of "coverage denial".         GRS 304.17A.       External Appeal Cost - Notification that the insurer will be responsible for the cost of the external review, however, the covered person.         GRS 304.17A.       External Appeal Cost - Notification that the insurer will be responsible for the cost of the external review index in order accords from bothe insurer & any provider	Statute/Rule	(Checklist must be submitted with filing – attach as a PDF if filing electronic Description	Yes	No	Page #
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523 Bulletin 2011-04       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- 107(2)(a) and (b) with be provided within 30 calendar days or within 24 hours of receipt of clain/appeal but no greater than the maximum of 72 hours if additional information is needed for an expedited bot 6 KAR 17:280         KRS 304.17A- 17(2)       External Appeal - Guidelines for requesting an external review – four months.         KRS 304.17A- 17(2)       External Appeal - Guidelines for requesting an external review – four months.         KRS 304.17A- 17(2)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 17(1)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 17(2)       Definition of "adverse benefit determination" and Definition of "coverage denial".         StRS 304.17A- 17(2)       Definition of the coverage denial".         StRS 304.17A- 17(2)       Definition of the coverage person.         KRS 304.17A- 225(5)       review decision favors the coverage person.         KRS 304.17A- 225(5)       review decision favors the coverage person.         KRS 304.17A- 225(5)       review decision favors the covereq perso		<b>External Appeal Disclosure -</b> Must disclose the availability of an			
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KRS 304.17A- 17(2)       External Appeal - Guidelines for requesting an external review – four months.         KRS 304.17A- 12(3)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 17(1)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 17(1)       Definition of "adverse benefit determination" and Definition of "coverage denial".         Substring 2011-04       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.         Subletin 2011-08       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 sulletin 2011-04         KRS 304.17A- 123(5)       Appeal Medical Authorization - Authorization for the independent review decision favors the covered person.         KRS 304.17A- 123(4)       Confidentially for External Appeal - A statement relating to the confidentiality of medical records and external review process.         Kettucky Mandated Benefits       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.		-			
517(2)       four months.         CR8 304.17A-       four months.         523(3)       CK8 304.17A-         CK8 304.17A-       Definition of "adverse benefit determination" and Definition of "coverage denial".         500(1)       "coverage denial".         Sulletin 2011-04       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.         Sulletin 2011-08       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 sulletin 2011-04         KRS 304.17A-       Appeal Medical Authorization - Authorization for the independent review decision favors the covered person.         KRS 304.17A-       Confidentially for External Appeal - A statement relating to the confidentially of medical records and external review process.         KRS 304.17A-       Statement Coverage for newborn to meet deductible or charge premium for the first 31 days. Cannot require the newborn to meet deductible or charge premium for the first 31 days.					
KRS 304.17A- (23(3)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 100(1)       Definition of "adverse benefit determination" and Definition of "coverage denial".         KRS 304.17A- 107(1)       Definition of "adverse benefit determination" and Definition of "coverage denial".         Sulletin 2011-04       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.         Sulletin 2011-08       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- 223(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- 223(9)       Confidentially for External Appeal - A statement relating to the confidentiality of medical records and external review process.         KRS 304.17A- 130       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.	<u>617(2)</u>				
223(3)       Definition of "adverse benefit determination" and Definition of "coverage denial".         S00(1)       "coverage denial".         CNRS 304.17A-       "coverage denial".         507(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of "coverage denial".         S17(1)       Washington of "adverse benefit determination" and Definition of a full deniality of medical records and information relating to an internal or external appeal.         S11(1)       S11(1)       External Appeal Cost - Notification that the insurer will be responsible for the cost of the external review; however, the covered person.         S23(5)       Wave decision	KRS 304.17A-				
600(1)       "coverage denial".         KRS 304.17A- i17(1)       "coverage denial".         Sulletin 2011-04       Mathematical Science (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.         Sulletin 2011-08       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 sulletin 2011-04         Sulletin 2011-04       review decision favors the covered person.         KRS 304.17A-       Appeal Medical Authorization - Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider         KRS 304.17A-       Confidentially for External Appeal - A statement relating to the coifidentiality of medical records and external review process.         KRS 304.17A-       Newborn - Coverage for newborn to indeet 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.	<u>623(3)</u>				
KRS 304.17A- 517(1)       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.         806 KAR 17:290 Section 1       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 sulletin 2011-04         KRS 304.17A- to225(5)       External Appeal Medical Authorization - Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider         KRS 304.17A- to23(4)       Confidentially for External Appeal - A statement relating to the confidentially of medical records and external review process.         Kentucky Mandated Benefits       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-				
617(1)       Bulletin 2011-04         Bulletin 2011-04       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.         Section 2       Bulletin 2011-08         Sulletin 2011-08       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-       Appeal Medical Authorization - Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider         KRS 304.17A-       Confidentially for External Appeal - A statement relating to the confidentiality of medical records and external review process.         KRS 304.17A-       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.	<u>600(1)</u>	"coverage denial".			
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806 KAR 17:290 Section 2 Bulletin 2011-08       position & telephone number of a contact person who can provide information relating to an internal or external appeal.         801 etin 2011-08       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- 523(5)       Appeal Medical Authorization - Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider         KRS 304.17A- 523(9)       Confidentially for External Appeal - A statement relating to the confidentiality of medical records and external review process.         Kentucky Mandated Benefits       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.					
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KRS 304.38-199 Advisorypremium payment may be required to continue coverage beyond the first 31 days.Dpinion 2005-07	KRS 304.17A-	31 days. Cannot require the newborn to meet deductible or			
Advisory the first 31 days.	<u>139</u>	· ·			
<b>Dpinion 2005-07</b>	KRS 304.38-199				
		the first 31 days.			
Auopicu - Coverage required the same for regarily adopted children		Adopted - Coverage required the same for legally adopted shildren			
	<u>KRS 304.17A-</u> <u>140</u>				
a natural child.	170				
	KRS 304.18-035				
must provide coverage for healthcare treatment in an Ambulatory					
Surgical center.					

Statute/Rule	(Checklist must be submitted with filing – attach as a PDF if filing electronic Description	Yes	No	Page #
KRS 304.18-	<b>Extension of Benefits Hospital -</b> All group policies/certificates	105	110	I uge "
<u>126(4)(a)</u>	must provide a reasonable extension of benefits for hospital			
Advisory	confinement when the group changes carriers in accordance with			
<b>Opinion 2010-03</b>	the statute.			
KRS 304.18-	Extension of Benefits Disability - All group policies/certificates			
126(4)(b)	must provide a reasonable extension of benefits for total disability			
Advisory	when the group changes carriers in accordance with the statute.			
<b>Opinion 2010-03</b>				
KRS 304.17A-	Health Care Provider/Provider Defined - All health insurance			
<u>005(23)</u>	policies must define doctor to include optometrists, osteopaths,			
KRS 304.18-095	physicians, chiropractors, and dentists.			
KRS 304.18-097				
KRS 304.18-095	Payments for Certain Providers – All policies must pay			
KRS 304.18-0363	optometrists, osteopaths, physicians, chiropractors or podiatrists;			
KRS304.18-097 KRS 304.38-196	for services for licensed psychologists or licensed clinical social workers; and services for dentists as outlined in these statutes.			
KRS 304.38-190 KRS 304.38-1933	workers, and services for denuisis as outlined in these statules.			
KRS 304.38-195				
KRS 304.38-1955				
KRS 304.17A-	Limitations/Exclusions - Limits on coverage of any treatment,			
<u>505</u>	procedure, a drug, or devise shall be defined and fully disclosed in			
KRS 304.17A-	the policy and/or certificate.			
<u>540</u>				
KRS 304.17A-	Rewards/Wellness Incentives – Items outlined in this statute are			
<u>098</u>	not considered inappropriate inducement if disclosed in the policy;			
	however, must make allowances for members with medical			
VDC 204 174	conditions, must be voluntary. Registered Nurse First Assistant Coverage – If coverage for a			
<u>KRS 304.17A-</u> <u>146</u>	surgical first assistant must also cover registered nurse first			
<u>140</u>	assistant			
KRS 304.17A-	Certified Surgical Assistant/Physician Assistant – If a health			
147	plan covers surgical first assisting it must cover a certified surgical			
KRS 304.17A-	assistant or physician assistant.			
1473	1 5			
KRS 304.17A-	Dental Procedure Anesthesia - All health benefit plans must			
<u>149</u>	cover anesthesia for dental procedures in accordance with this			
	statute.			
KRS 304.17A-	Copayment for Chiropractor or Optometrist- Copayment or			
<u>175</u>	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			
<u>KRS 304.17A-</u> 177	<b>Copayment for Occupational or Physical Therapist</b> – Copayment or coinsurance for an occupational or physical therapist			
177 Advisory	must be no greater than the copayment or coinsurance of a			
<u>Advisory</u> Opinion 2012-05	physician or osteopath for an office visit. As stated in the			
<u> </u>	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-	Provider Directories – All health benefit plans that utilize a			
<u>254</u>	network of providers must provide upon request a current provider			
KRS 304.17A-	directory to insureds in accordance with these two statutes.			
<u>510</u>				
KRS 304.17A-				
<u>590</u>				
<u>KRS 304.17A-</u>	<b>Drug Formulary</b> – All health benefit plans that utilize a drug			
<u>535</u>	formulary must provide this listing to the insureds upon request,			

	(Checklist must be submitted with filing – attach as a PDF if filing electronic			
Statute/Rule	Description	Yes	No	Page #
KRS 304.17A-	provide for a waiver program, limitations on generic substitution in			
<u>505(j)</u>	accordance with this statute and regulation			
806 KAR 17:250				
	The Drug Formulary Listing must also comply with Part			
	156.122 of the ACA.			
KRS 304.17A-	Out of Network Benefits - Managed care plans must offer a			
<u>550</u>	health benefit plan with out-of-network benefits in accordance with			
	this statute.			
KRS 304.17A-	OB/GYN Access without Referral - All health benefit plans			
<u>647</u>	cannot require a referral for annual pap.			
KRS 304.17A-	Referral from PCP limitation – A PCP can make a referral for up			
<u>645</u>	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-	Prescription Eye Drop Coverage - All health benefit plans must			
<u>166</u>	cover prescription eye drops in accordance with this statute,			
	including providing an additional bottle every 3 months.			
KRS 304.17A-	Anti-Cancer Medications Coverage – All health benefit plans			
<u>172</u>	that cover anti-cancer medications shall not require a higher			
	copayment, deductible, or coinsurance amount than it requires 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-	Tobacco Cessation Medications & Services – All health benefit			
<u>168</u>	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.			
<u>KRS 441.052</u>	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 Requiremen				
NETWORK	List the name of the network this product will utilize and	NETWO	RK NAM	<b>E:</b>
NAME:	whether this network has been approved.			
		Approva	l Date:	
				-
FORMULARY	List the name of the formulary this product will utilize and			
NAME:	provide the excel spreadsheet of the formulary to allow			
	verification of drug counts.			
EXCHANGE	WILL THIS PRODUCT BE OFFERED ON THE			
INTENTION:	EXCHANGE?			
	Lifetime Limits - No Lifetime Dollar Limits are allowed to be 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.			
	HSA PLAN DESIGNS – All services must accrue towards the			
	deductible.			
	Please indicate on each schedule whether the schedule will be			
	offered with an HSA.			
	Out of Pocket Maximum –			
	$1^{\prime}$ (1) $1^{\prime}$ (1) $1^{\prime}$ (1) $1^{\prime}$ (1) ton calt only correspond with $1^{\prime}$ (1) (1) for other	1		
	2017: \$7,150.00 for self-only coverage and \$14,300.00 for other			
	than self-only coverage.			
	than self-only coverage.			

## NON-GRANDFATHERED SMALL GROUP HEALTH BENEFIT PLAN\* (MAJOR

**MEDICAL COVERAGE) CHECKLIST** with Essential Health Benefits (continued) (Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)

(Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)					
Statute/Rule	Description	Yes	No	Page #	
	FOR HSA-qualified High Deductible Health Plans –				
	Maximum for 2017 = \$6,550 for self-only coverage and \$13,100				
	for other than self-only coverage.				
	Maximum for 2018 = \$6,650 for self-only coverage and \$13,300				
	for other than self-only coverage.				
	<b>Rescission prohibition</b> - Rescission is prohibited except for fraud				
45 CFR 155.430	or material misrepresentations <b>Retroactive Terminations</b> – The policy must comply with the				
<u>45 CFK 155.450</u>	requirements of this provision of the 2017 Final Benefit and				
	Payment Parameters regulation.				
<u>45 CFR</u>	Acceptance of Certain Third Party Payments – The				
<u>156.1250</u>	policy/insurer must comply with the requirement of this provision of the 2017 Final Benefit and Payment Parameters regulation,				
	including any downstream entities. This includes both premium				
	payments and cost-sharing payments.				
KRS 304.17A-	Dependent coverage - Dependents may be covered to age 26				
256 KDS 204 17A	without restrictions on marital, financial, or student status.				
<u>KRS 304.17A-</u> 140					
	Incarceration Special Open Enrollment – Must allow someone				
	being released from incarceration a 60 days special enrollment.				
	<b>Schedules of Benefits</b> – The Department is not allowing variability				
	in the schedules of benefits that would affect the rates/premiums/AV calculator.				
	Also, the snapshot of the input and output of the AV Calculator				
	must be submitted with each schedule of benefits for review.				
	The AV calculator snapshot needs to include on the snapshot				
	the schedule of benefit form number to allow verification of				
	input. Also, if there is justification for the AV calculator, it				
	must be submitted with the snapshot. Snapshots must be filed in both the form filing and the binder.				
Uniform	The definitions of the policy/certificate cannot conflict with the				
Glossary &	definitions in the Uniform Glossary prescribed by the ACA.				
Summary of					
Benefits & Coverage	The Summary of Benefits & Coverages (SBC) requirements have changed from 4 two side pages to 2 two side pages. Please ensure				
Coverage	all SBCs provided are in compliance with the new regulation.				
Essential Health B					
<b>Ambulatory Patie</b>	nt 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.				

CAL COVERAGE) CHECKLIST WITH ESSENTIAL HEALTH BENEFITS (CONTINUED (Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)

Stated - ID	(Checklist must be submitted with filing – attach as a PDF if filing electronica			<b>D</b> //
Statute/Rule	Description	Yes	No	Page #
<b>Emergency Servic</b>	es			
KRS 304.17A-	Must meet the definition in this statute and comply with the ACA			
<u>640</u>	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-	"Stabilize" means to provide treatment that assures that no material			
<u>641(1)</u>	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	as outlined in the 2017 Kentucky Deneminark			
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 Covera				
KRS 304.17A-	Benefits may not be restricted to less than 48 hours following a			
<u>145</u>	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	<b>Nursery Care</b> – 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 treatm	nent		
KRS 304.18-036	Inpatient behavioral health services – must be in parity to			
KRS 304.18-130	sickness/illness coverage.			
KRS 304.18-150	Outpatient behavioral health services– must be in parity to			
KRS 304.18-160	sickness/illness coverage.			
KRS 304.18-170	Inpatient mental health and substance abuse – must be in parity to			
KRS 304.17A-	sickness/illness coverage.			
IXINO OUT.I//I*	siekness/mness coverage.			

	(Checklist must be submitted with filing – attach as a PDF if filing electronic			
Statute/Rule	Description	Yes	No	Page #
<u>661*</u>	Outpatient mental health and substance abuse – must be in parity to			
	sickness/illness coverage.			
	*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			
<b>D</b> uccovintion Duuc	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".			
	the LTD-benefimark plan.			
	Must contain an exception policy in compliance with ACA			
	regulations, including timeframes.			
	6 / 6			
	Must comply with the Drug Formulary listing requirements 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)			
<u>140</u>				
KRS 304.17A-	Therapeutic food, formulas, supplements, & low-protein modified			
<u>258</u>	food products for inborn error of metabolism & genetic conditions			
	(prior authorization requirements)			
KRS 304.17A-	Milk fortifier – 100% human diet – all health benefits plans must			
139	provide coverage for 100% human diet as outlined in this statute.			
KRS 304.17A-	Step Therapy Override - All health benefit plans must have an			
<u>163</u>	override of restrictions on medication sequence in step therapy or			
KRS 304.17A-	fail-first protocol			
<u>535</u>				
806 KAR 17:250				
<u>KRS 304.17A-</u>				
165 Habilitative Servic				
Tabilitative Servic				
	The Habilitative coverages must be in compliance with the			
	ACA definition of Habilitation Services. Please review the coverage and exclusion 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 serv				
	<b>Physical Therapy</b> – must cover a minimum of 25 visits			
	Occupational Therapy – must cover a minimum of 25 visits			
	<b>Speech Therapy</b> – must cover a minimum of 25 visits			
	Pulmonary Rehabilitation – must cover a minimum of 25 visits			
	<b>Cardiac Rehabilitation</b> – must cover a minimum of 36 visits			
	Manipulation Therapy – must cover a minimum of 20 visits			
	<b>Post-Cochlear Implant Aural Therapy</b> – must cover a minimum			
	of 30 visits			

Statute/Rule	(Checklist must be submitted with filing – attach as a PDF if filing electronic Description	Yes	No	Page #
	<b>Cognitive Rehabilitation</b> – must cover a minimum of 20 visits.			0
	Durable Medical Equipment, Medical Supplies and Appliances			
	Orthotic devises			
Laboratory service				
Laboratory service			1	
	Complex imaging services			
	Outpatient laboratory services			
	Outpatient x-ray services			
	Allergy Tests			
Other				
	<b>Private-Duty Nursing</b> – must cover at least 250 eight hour visits per year.			
<u>KRS 304.18-037</u>	<ul> <li>Home Health Care Services – must cover at least 100 visits per year. The minimum to be considered a visit is four (4) hours.</li> <li>[preempts KY mandate]</li> <li>Skilled Nursing Facility – must cover at least 90 days per year</li> </ul>			
	Samee Autoing Fuency must cover at least 50 days per year			
	<b>Inpatient Rehabilitation Facility</b> – must cover at least 60 days per year.			
<u>KRS 304.17A-</u> <u>132</u>	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)	<b>Hospice</b> - All health benefit plans must cover Hospice at least equal to Medicare benefits. <b>Cannot apply deductible unless the</b> <b>plan design is a High Deductible Health Plan with an HSA.</b>			
	Must provide same coverage in and out of network at same cost share, including HMO plan designs.			
Preventive and we			1	
	Preventive Services - Preventive services must be providedwithout cost sharing (no – co-payments, co-insurance ordeductibles 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 <u>Check exclusions for</u> <u>conflicts with the recommendations.</u>			
KRS 304.17A-	Preventive care & screenings for infants, children, & adolescentssupported by the Health Resources & Services AdministrationCheck exclusions for conflicts with the recommendations.Women's Preventive Care and Screenings including			
<u>135</u> KRS 304.17A-	contraceptives, breast feeding support, sterilization procedures. Check exclusions for conflicts with the recommendations.			

133       Image: Constraint of the second seco	Statute/Rule	(Checklist must be submitted with filing – attach as a PDF if filing electronic Description	Yes	No	Page #
KRS 304.38-1935       Image: Spanded Mammography - Expanded mammogram coverage required for insureds of any age with a diagnosis of breast cancer must be included.         KRS 304.17A-       Colorectal - Coverage for colorectal cancer examinations and laboratory tests specific in current American Cancer Society guidelines At no cost share         Chronic Discase management and pediatric services, including oral and vision care         KRS 304.17A-       Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.         KRS 304.17A-       Goehlear - All plans shall provide coverage for medical surgical benefits for mastectomy. Glagoosis and treatment of endometrioses and endometritis and bone density testing a outlined in the statute. Mastectomy coverage cannot be required to be on an outpacient basis.         KRS 304.17A-       Cancer Clinical Trials coverage for diabetes including equipment, supplies, outpacient self-management training, and education as outlined in this statute.         KRS 304.17A-       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A-       Breast Cancer - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0955       TMJ - The mandated coverage for treatment of treatment of the cancer structed in accordance with the statute.         KRS 304.817040       Pediatric Dental Services (See 2017 Kentucky Benchmark Pediatric Dental Benefit Checklist for specific benefits)         Coverage		×.			0
KRS 304.18-098         Expanded Mannography - Expanded mannogram 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 304.17A- 134         Mastectomy/Endometrises/Endometrils/Bone Density Testing -for expanse-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 outpacient basis.           KRS 304.17A- 136         Cancer Cluical 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- 138         Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.           KRS 304.18.4055         TMJ - The mandated coverage for treatment of thesat cancer must be provided in accordance with the statute.           KRS 304.81.9057         TMJ - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.           KRS 304.81.9056         TMJ - The mandated coverage fo	KRS 304.38-1935				
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- 103         Cochlear - All plans Shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.           KRS 304.17A- 104         Cochlear - All plans Shall provide coverage for modellar implants for persons diagnosed with profound hearing impairment.           KRS 304.17A- 114         Cochlear - All plans Shall provide coverage for mediate argical benefits for mastectomy, diagnosis and treatment of endometrineses and endometritis and hone density testing as outlined in the statute. Mastectomy coverage cannot be required to be on an outpatient basis.           KRS 304.17A- 136         Diabetts - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.           KRS 304.17A- 135         Diabetts - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.           KRS 304.17A- 135         Diabetts - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.           KRS 304.18-095         TMJ - The mandated coverage for treatment of thest statute.           KRS 304.18-095         TMJ - The mandated coverage for treatment of thest statute. <td></td> <td></td> <td></td> <td></td> <td></td>					
mist be included.         mist be included.           ZS7         Colorectal - Coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines At no cost share         Image: Control Disease management and pediatric services, including oral and vision care           Chronic Disease management and pediatric services, including oral and vision care         Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.           IM         Cochlear - All plans shall provide coverage for modelal 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 rotine 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         Diabetes - The mandated coverage for treatment of breat cancer must be provided in accordance with the statute.           KRS 304.17A- 135         Tour The mandated coverage for treatment of Temporomanibular joint disorders (TMJ) and craniomanibular KRS 304.18-0365           KRS 304.17A- 135         Tour The mandated coverage for treatment of Temporomanibular point disorders (TMJ) and craniomanibular KRS 304.38-1937	<u>KRS 304.18-098</u>				
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- 167 represense incurred ball provide coverage for cochelaer implants into persons diagnosed with profound hearing impairment.         KRS 304.17A- 150 represense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of be on an outpatient basis.       Mastectomy/Endometritis/Bone Density Testing KRS 304.17A- 164         KRS 304.17A- 166       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- 186       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A- 187       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A- 188       TMJ - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.         KRS 304.17A- 197       Tawl Joorders must be provided in accordance with the statute.         KRS 304.17A- 198       TMJ - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.         KRS 304.17A- 199       Temporomandibular joint disorders (TMJ) and cranin		1			
257       Iaboratory 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_10       Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.         KRS 304.17A_1134       Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.         KRS 304.17A_1134       Mastectomy/Endometrike/Rone Density Testing as outlined in the statute. Mastectomy coverage cannot be required to be on an outpatient basis.         KRS 304.132-136       endometrike/Rais coverage - Health bencfit 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-128       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A-138       Diabetes - Coverage for tabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A-148       Breast Cancer - The mandated coverage for treatment of thest cancer must be provided in accordance with the statute.         KRS 304.18-0955       TMJ - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular joint disorders (TMJ) and craniomandibular KRS 304.38-1937         Yediatric Dental Benefit Checklist for specific benefits)       Coverage m	KRS 304.17A-				
Chronic Disease management and pediatric services, including oral and vision care         KRS 304.174_10       Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.         KRS 304.17A_10       Mastectomy/Endometritis/Rone 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 overage cannot be required to be on an outpatient basis.         KRS 304.17A_156       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_156       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A_155       Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.         KRS 304.17A_155       Breast Cancer - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0365       TMJ       - The mandated coverage for treatment of each statute.         KRS 304.18-0365       Fordowers must be provided in accordance with the statute.         Z017 Kentucky       Pediatric Dental Services (Sec 2017 Kentucky Benchmark for specific benefits)         2017 Kentucky       Pediatric Vision Services (Sec 2017 Kentucky					
KRS 304.17A- 131       Cochlear - All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.         KRS 304.18.6093       Mastectomy/Endometriose/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- 136       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.184.0985       Breast Cancer - The mandated coverage for the treatment of breat cancer must be provided in accordance with the statute.         KRS 304.184.0985       TMJ - The mandated coverage for treatment of breat cancer must be provided in accordance with the statute.         KRS 304.18-0365       TMJ - The mandated coverage for treatment of treat cancer must be provided in accordance with the statute.         2017 Kentucky Benchmark       Pediatric Dental Services (See 2017 Kentucky Benchmark for specific benefits)         2017 Kentucky Benchmark       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific benefits)         2017 Kentucky Benchmark       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific bene					
131       for persons diagnosed with profound hearing impairment.         KRS 304.18-093       Mastectomy/Endometrios/Endometriis/Bone Density Testing         KRS 304.17A-       For expense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of exoluted in the statute. Mastectomy coverage cannot be required to be on an outpatient basis.         KRS 304.17A-       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-       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A-       Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0905       TMJ - The mandated coverage for treatment of Sen KAS 304.38-1937         Jaw Go KAR 17A-090       Temporomandibular joint disorders (TMJ) and craniomandibular jaw disorders must be provided in accordance with the statute.         2017 Kentucky       Pediatric Dental Services (See 2017 Kentucky Benchmark Benchmark Benchmark Section specific benefits)         2017 Kentucky       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific benefits)         8 not exclude vision training and orthoptics       One complet explacement set if medically necessary py er year         9 One coutine vision examination or refraction only in lieu of a	Chronic Disease m	anagement and pediatric services, including oral and vision care			
KRS 304.18-0983       Mastectomy/Endometrioses/Endometriis/Bone Density Testing         KRS 304.17A- 134       -For expense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of endometrioses and endometriis 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 endometrioses and endometriis, and bone density testing as outpatient basis.         KRS 304.17A- 136       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.18-0985       Breast Cancer - The mandated coverage for treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0985       TMJ - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular jaw disorders must be provided in accordance with the statute.         KRS 304.38-1937       Z017 Kentucky Pediatric Dental Benefit 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)       Be limited to a recipient who is under age twenty-one (21)         Be limited to a complete examp req ar       One complete examp req ar         One complete examp req ar       <					
IXRS 304.17A- 134       -For expense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of endometrioses and endometriis 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- 136       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.18-0365       Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0365       TMJ - The mandated coverage for treatment of tenspromandibular 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 Pediatric Dental Benefit Checklist for specific benefits)         2017 Kentucky       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific benefits)         Be limited to a recipient who is under age twenty-one (21)       Be limited to a recipient who is under age twenty-one (21)         Wast not exclude vision training and orthoptics       One complete exam per year with one complete replacement set if medically necessary per year         One contact lens fitting and evaluation per year with one complete exat peryeage (or					
134 KRS 304.38-1936       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       Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0985       TMJ - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular is disorders must be provided in accordance with the statute.         2017 Kentucky Benchmark       Pediatric Dental Services (See 2017 Kentucky Benchmark Pediatric Dental Benefit Checklist for specific benefits)         2017 Kentucky Benchmark       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific benefits)         2017 Kentucky Benchmark       Pediatric to a recipient who is under age twenty-one (21)         Wust tot exclude vision training and orthoptics       One complete examples frames and lenses per year with one complete set or year         One conduct eless fitting and evaluation per year       One conduct lens fitting and evaluation per year         One contact lens fitting and evaluation					
KRS 304.38-1936       endometricses 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- 136       Diabetes - Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.         KRS 304.17A- 135       Breast Cancer - The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.         KRS 304.18-0985       TMJ - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular Set Sources (See 2017 Kentucky Benchmark Pediatric Dental Services (See 2017 Kentucky Benchmark Pediatric Dental Services (See 2017 Kentucky Benchmark Pediatric Dental Services (See 2017 Kentucky Benchmark Pediatric Dental Benefit Checklist for specific benefits)         2017 Kentucky       Pediatric Vision Services (See 2017 Kentucky Benchmark for specific benefits)         2017 Kentucky       Peliatric 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 complete examp repar       • One complete set of eyeglass frames and lenses per year with the complete replacement set if medically necessary per year         • One set of contacts per year (or theyearly equival					
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(Checklist must be submitted with filing – attach as a PDF if filing electronically via SERFF)

Statute/Rule	Description	Yes	No	Page #
	member turns 21.			
Prohibited Provisi				
<u>KRS 304.5-160</u>	Abortion - Health insurance contracts cannot cover abortion			
	except by rider except by an optional rider for which there must be			
	paid an additional premium.			
<u>KRS 304.12-</u>	AIDS/HIV - Health insurance policies/certificates may not limit,			
<u>013(5)(a) &amp; (b)</u>	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-	Domestic Violence – Cannot deny coverage, refuse to issue or			
<u>155</u>	renew, cancel or otherwise terminate, restrict, or exclude any			
KRS 304.12-211	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 comply			
KRS 304.14-380	with this statute.			
<u>KRS 304.17A-</u>	Telehealth Exclusion - A Health Benefit Plan shall not exclude a			
<u>138</u>	service from coverage solely because the service is provided			
806 KAR 17:270	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			
<u>000 KAK 17:030</u>	deny coverage because a proposed insured is eligible for Medicaid			
Advicony	<b>Discretionary Clauses</b> - The Department does not allow			
Advisory Opinion 2010-01	Discretionary Clauses - The Department does not allow Discretionary Clauses in insurance policies.			
<u>Opinion 2010-01</u>	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.