Form No:

Kentucky Department of Insurance

Health Product Review

ACA STANDARDIZED OPTIONS BRONZE PLAN CHECKLIST

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

Statute/Rule	Description	Yes	No	Page #
General Requirements				
CATASTROPHIC PLANS	**Check here if this for a Catastrophic Plan and see the Catastrophic Plan section at the end of the checklist for additional information on Catastrophic Plans.**			
KRS 304.18-114	**CONVERSION PLANS -** Please review this statute for information regarding conversion eligibility and other 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 304.14-140 KRS 304.14-150 KRS 304.14-160 KRS 304.14-360 KRS 304.17-030 KRS 304.17-040 KRS 304.38-080	**Standard Provisions/Construction of Policies** – All policies must conform to the requirements of these statutes in format and content. **Format of Policy/Required Provisions** – all individual policies must conform to the requirements in this statute.			
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 304.14-430	**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 304.17-170	**Free Look/Right to Examine** – All policies must allow the insured at least a 10 day free look provision in accordance with this statute.			
KRS 304.14-230(1)	**Electronic Delivery -** The policy may be delivered by electronic transfer, by agreement between the insurer and the insured or the person entitled to receive the policy.			
KRS 304.17-050 KRS 304.14-180	**Entire Contract** – All individual policies must contain a provision as outlined in these statutes.			
KRS 304.17-060 KRS 304.17-370	**Contestability** – The policy cannot be contested for misstatements, except for fraudulent misstatements after three (3) years from the date of the application. **Incontestability after Reinstatement** – A policy shall only be contestable on account of fraud or material misrepresentation on the reinstatement application and limited to the same time period of the policy.			
KRS 304.17-070 KRS 304.17A-243	**Grace Period** – All policies must contain a grace period of not less than 30 days. **PREEMPTED FOR EXCHANGE PLANS**			

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	RECEIVING PREMIUM TAX CREDITS– SEE ACA SECTION			
KRS 307.17-080	**Reinstatement** – All policies must contain a reinstatement provision in compliance with this statute including the limitation of collecting only 60 days of back premium.			
KRS 304.17-090	**Notice of Claim** – All policies must contain a provision requiring claims to be filed within 60 days.			
KRS 304.17-100	**Claim Forms** – The insurer must provide a claim form within 15 days or accept written proof covering the occurrence, the character, and the extent of the loss from the claimant.			
KRS 304.17-110	**Proof of Loss** – All policies must contain a provision concerning that the proof of loss is 90 days or 1 year if not reasonable to provide the proof of loss.			
KRS 304.17-130	**Payment of Claims at Death** – All policies must contain a provision for the payment of indemnity for the loss of life in accordance with this statute.			
KRS 304.17-140	**Physical Examination & Autopsy** – All policies must contain a provision concerning physical examination and autopsy in compliance with this statute.			
KRS 304.17-150	**Legal Actions** – All policies must contain a provision in accordance with the timeframes in this statute. (60 days after proof of loss or no longer than 3 yrs.)			
KRS 304.17-160	**Beneficiary Change** – All policies must contain a provision that allows the insured to change beneficiaries in accordance with this statute.			
KRS 304.17-270	**Right to Refuse Renewal** – All policies must contain a provision in compliance with this statute relating to the right to refuse renewability.			
KRS 304.17A-095(4)	**12 Month Rate Guarantee** – All policies must contain a 12 month rate guarantee at the rate in effect on the date of issue or date of renewal **[Ky Pre-empted] – ACA requires all individual products to renew January 1st of each year. Make sure language concerning rate guarantee outlines the first year could possibly be less than 12 months and the rate could change effective on their next renewal.**			
KRS 304.17A-005(11)	**Eligible Individual Defined** – All policies must contain a definition of eligible individual as outlined in this statute.			
KRS 304.17A-245	**Cancellation Requirements** – All policies must adhere to the provisions of this statute concerning the cancellation of a policy.			
KRS 304.17A-500	**Additional Required Definitions** – All policies must contain definitions for a covered person, grievance, insurer, record, and utilization management.			
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-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) 806 KAR 18:030 KRS 304.38-185	**Coordination of Benefits -** All health benefit plans must coordinate benefits with other health benefit plans in accordance with this statutes and regulation.			

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KRS 304.17-415 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 304.17-120 KRS 304.12-235 KRS 304.17A-702 KRS 304.17A-730 806 KAR 17:360 806 KAR 12:092	**Time of Payment of Claims-** All claims must be paid in thirty (30) days, after 30 days must pay interest on claim Organ transplant claims must be paid within 60 calendar days.			
Grievance and Appeals				
KRS 304.17-412 KRS 304.38-225	**Utilization Review Requirements** – All insurers must comply with the statute if they provide for utilization review of benefits.			
KRS 304.17A-607	**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 UR AGENT: **If using a 3rd party UR agent, verify that the licensed entity is listed as a client of the 3rd party's registration with the Department's Utilization Review Branch.**			
KRS 304.17A-617 Bulletin 2011-08	**Internal Appeal Disclosure** - Must disclose the availability of an internal appeal process.			
KRS 304.17A-623 Bulletin 2011-04	**External Appeal Disclosure** - Must disclose the availability of an external review of an adverse determination or coverage denial with a medical issue by an independent review entity certified by the Department.			
KRS 304.17A-617(2)(a) and (b) KRS 304.17A-607(1)(i) 806 KAR 17:280	**Internal Appeal Timeframe** - Standard internal appeal decision must be provided within 30 calendar days or **within 24 hours of receipt of claim/appeal but no greater than the maximum of 72 hours if additional information is needed for an expedited review decision**			
KRS 304.17A-617(2) KRS 304.17A-623(3)	**External Appeal** - Guidelines for requesting an external review – four months			
KRS 304.17A-600(1) KRS 304.17A-617(1) Bulletin 2011-04	Definition of "adverse benefit determination" and Definition of "coverage denial"			
806 KAR 17:280 Section 4 806 KAR 17:290 Section 2 Bulletin 2011-08	**Appeal Instructions** - Instructions for requesting an oral (expedited) or written (non-expedited) appeal, including the position & telephone number of a contact person who can provide information relating to an internal or external appeal			
KRS 304.17A-625(5) KRS 304.17A-623(5) Bulletin 2011-04	**External Appeal Cost** - Notification that the insurer will be responsible for the cost of the external review; however, the covered person will be assessed a filing fee of $25, which may be waived in case of financial hardship or refunded if the external review decision favors the covered person.			
KRS 304.17A-623(4)	**Appeal Medical Authorization** - Authorization for the independent review entity to access all relevant medical records from both the insurer & any provider			
KRS 304.17A-623(9)	**Confidentially for External Appeal** - A statement relating to the confidentiality of medical records and external review process.			
Kentucky Mandated Benefits				

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KRS 304.17A-139 KRS 304.17-042 KRS 304.38-199 Advisory Opinion 2005-07	**Newborn -** Coverage for newborn children is required for the first 31 days. **Cannot require the newborn to meet deductible or charge premium for the first 31 days.** Notice of birth and premium payment may be required to continue coverage beyond the first 31 days.			
KRS 304.17A-140	**Adopted -** Coverage required the same for legally adopted children or any child for which the insured is a court-appointed guardian as a natural child.			
KRS 304.17-317	**Ambulatory Surgical Centers** – All policies providing coverage must provide coverage for healthcare treatment in an Ambulatory Surgical center.			
KRS 304.17A-005(23)	**Health Care Provider/Provider Defined -** All health insurance policies must define doctor to include optometrists, osteopaths, physicians, chiropractors, and dentists.			
KRS 304.17-305, KRS 304.17-3185 KRS 304.17-315 KRS 304.17A-173 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 KRS 304.17A-540	**Limitations/Exclusions -** Limits on coverage of any treatment, procedure, a drug, or devise shall be defined and fully disclosed in the policy and/or certificate.			
KRS 304.17A-098	**Rewards/Wellness Incentives –** Items outlined in this statute are not considered inappropriate inducement if disclosed in the policy; however, must make allowances for members with medical conditions, must be voluntary.			
KRS 304.17A-146	**Registered Nurse First Assistant Coverage –** If coverage for a surgical first assistant must also cover registered nurse first assistant			
KRS 304.17A-147 KRS 304.17A-1473	**Certified Surgical Assistant/Physician Assistant –** If a health plan covers surgical first assisting it must cover a certified surgical assistant or physician assistant.			
KRS 304.17A-149	**Dental Procedure Anesthesia –** All health benefit plans must cover anesthesia for dental procedures in accordance with this statute.			
KRS 304.17A-175	**Copayment for Chiropractor or Optometrist–** Copayment or coinsurance for a chiropractor or optometrist must be no greater than the copayment or coinsurance of a physician or osteopath			
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 the 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			

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	The Drug Formulary Listing must also comply with Part 156.122 of the ACA.			
KRS 304.17A-647	**OB/GYN Access without Referral** – All health benefit plans cannot require a referral for an annual pap smear exam.			
KRS 304.17A-645	**Referral from PCP limitation –** A PCP can make a referral for up to 12 months or for the contract period, whichever is shorter for a covered person with a chronic, disabling, congenital, or life threatening condition.			
KRS 304.17A-166	**Prescription Eye Drop Coverage** – All health benefit plans must cover prescription eye drops in accordance with this statute including providing an additional bottle every 3 months.			
KRS 304.17A-172	**Anti-Cancer Medications Coverage** - All health benefit plans that cover anti-cancer medications shall not require a higher copayment, deductible, or coinsurance amount than it 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 441.052	**Incarcerated Persons Coverage** – All policies must provide coverage for incarcerated persons who have NOT been convicted of a felony in accordance with this statute.			
ACA Requirements				
NETWORK NAME:	**List the name of the network this product will utilize and whether this network has been approved.**	**NETWORK NAME: _____ Approval date: _____**		
FORMULARY NAME:	**List the name of the formulary this product will utilize and provide the excel spreadsheet of the formulary to allow verification of drug counts.**			
EXCHANGE INTENTION:	**WILL THIS PRODUCT BE OFFERED ON THE 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 – This cannot be greater than the 2017: $7,150.00 for self-only coverage and $14,300.00 for other than self-only coverage. **2018: $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 for 2017 = $6,550 for self-only coverage and $13,100 for other than self-only coverage. **MAXIMUM FOR 2018 = $_____ for self-only coverage and $_____ for other than self-only coverage.**			
	Cost Share Reduction Out of Pocket Maximum for 2018 Plans -			

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	100-150% of FPL - $2,450 for self-only coverage and $4,900 for other than self-only coverage. **150-200% of FPL - $2,450 for self-only coverage and $4,900 for other than self-only coverage** **200-250% of FPL - $5,850 for self-only coverage and $11,700 for other than self-only coverage**			
	Rescission prohibition - Rescission is prohibited except for fraud or material misrepresentations			
45 CFR 155.430	**Retroactive Terminations** – The policy must comply with the requirements of this provision of the 2017 Final Benefit and Payment Parameters regulation.			
45 CFR 156.1250	**Acceptance of Certain Third Party Payments** – The 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 304.17-310 **KRS 304.17A-140**	**Dependent coverage -** Dependents may be covered to age 26 without restrictions on martial, financial, or student status.			
	Grace Period – Policies offered through the Exchange to individuals receiving premium tax credit must have a grace period of 90 days.			
	Native American Exemption – All plans must allow zero cost share for Native Americans in accordance with the ACA			
	Incarceration Special Open Enrollment – Must allow someone being released from incarceration a 60 day special enrollment.			
	Schedules of Benefits – 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 submitted with both the form filing and the binder.**			
STANDARDIZED OPTIONS – Bronze Level Benefit Requirements	The following items are required for the 2018 Standardized Bronze Option Plan in Kentucky. All other requirements of the ACA, Kentucky Revised Statutes, and Kentucky Administrative Regulations must be included as appropriate.			
62.79%	**Actuarial Value** The actuarial value of the this plan for the 2018 plan year. Please submit the AV calculator snapshot confirming this requirement.			
$6,650	**Deductible** - The deductible for the 2018 plan year			
$7,350	**Annual Limitation on Cost Sharing** - The cost share for the 2018 plan year			
40%	**Emergency Room Services** – The coinsurance for the 2018 4plan year			
$75.00	**Urgent Care** – The copayment for the 2018 plan year **not subject to the annual deductible**			

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40%	**Inpatient Hospital Services** – The coinsurance for the 2018 plan year			
$35.00	**Primary Care Visit** – The copayment for the 2018 plan year **not subject to the annual deductible**			
$75.00	**Specialist Visit** – The copayment for the 2018 plan year **not subject to the annual deductible**			
$35.00	**Mental Health/Substance Use Disorder Outpatient Office Visit** - The copayment for the 2018 plan year **not subject to the annual deductible**			
40%	**Imaging (CT/PET Scans, MRIs)** – The coinsurance for the 2018 plan year			
$35.00	**Speech Therapy** – The copayment for the 2018 plan year **not subject to the annual deductible**			
$35.00	**Occupational/Physical Therapy** The copayment for the 2018 plan year **not subject to the annual deductible**			
40%	**Laboratory Services** - The coinsurance for the 2018 plan year			
40%	X-rays & Diagnostic Imaging (Excludes X-rays & diagnostic imaging associated with office visits)			
40%	**Skilled Nursing Facility** - The coinsurance for the 2018 plan year			
40%	**Outpatient Facility Fee** – (e.g. Ambulatory Surgery Center) The coinsurance for the 2018 plan year			
40%	**Outpatient Surgery Physician/Surgical Services** - The coinsurance for the 2018 plan year			
$35.00	**Generic Drugs** - The copayment for the 2018 plan year **not subject to the annual deductible**			
$40.00	**Preferred Brand Drugs** – The copayment for the 2018 plan year (copay applies only after deductible has been met)			
$45.00	**Non-Preferred Brand Drugs** - The copayment for the 2018 plan year (copay applies only after deductible has been met)			
$50.00	**Specialty Drugs** - The copayment for the 2018 plan year (copay applies only after deductible has been met)			
Uniform Glossary & Summary of Benefits & Coverages	The definitions of the policy/certificate cannot conflict with the definitions in the Uniform Glossary prescribed by the ACA. The Summary of Benefits & Coverages (SBC) requirements changed effective 4-6-2016. Please ensure all SBCs provided are in compliance with this revised form and regulation			
	Exchange plans are required to offer at least one silver and one gold plan in each service area they offer exchange products.			
Essential Health Benefits				
Ambulatory patient services				
	Allergy testing and injections			
	High-dose chemotherapy for breast cancer			
	Office visit (primary care physician)			
	Office visit (specialist physician)			
	Outpatient facility fee			
	Outpatient surgery and facility fees			
	Sterilization Services for Males (Women's sterilization is covered in the Preventive Care section)			
	Reconstructive services to correct a deformity caused by disease, trauma, congenital anomalies or previous therapeutic process.			
	Telehealth services			
Emergency Services				

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KRS 304.17A-640	Must meet the definition in this statute and comply with the ACA definitions. • Cannot require prior authorization and • Cannot be limited to only services and care at participating providers;			
	Must be covered at **in-network cost-sharing level** (patient is not penalized for emergency care at out-of-network provider);			
	Must pay for out-of-network emergency services the greatest of: 1) the median in-network rate; 2) the usual customary & reasonable rate (or similar rate determined using the plan's or issuer's general formula for determining payments for out-of-network services); 3) the Medicare rate.			
KRS 304.17A-641(1)	"Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.			
	Ambulance Services - Both ground & air emergency ambulance must be provided at same cost-share for both in and out of network. Out of network may balance bill. - Non-emergency ambulance must be covered in-network as outlined in the 2017 Kentucky Benchmark			
Hospitalization				
	Inpatient facility services, including physical medicine and rehabilitation.			
	Surgical services, including anesthesia			
	Reconstructive services to correct a deformity caused by disease, trauma, congenital anomalies or previous therapeutic process.			
Maternity Coverage				
KRS 304.17A-145	Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section.			
	No prior authorization required for 48/96 hour hospital stay.			
	Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital.			
	Services following a miscarriage			
	Services include physician care for a normal or complicated pregnancy			
	Obstetrical care through the end of the pregnancy and the immediate post-partum period.			
	Services cannot be limited based on the location of the labor and delivery			
KRS 304.17-185	**Nursery Care –** An offer to purchase coverage for routine nursery care for up to 5 days – N/A if routine nursery care is in the contract.			
Mental health and substance use disorder services, including behavioral health treatment				
KRS 304.17A-661	Inpatient behavioral health services must be in parity to sickness/illness coverage.			
KRS 304.17A-661	Outpatient behavioral health services must be in parity to sickness/illness coverage.			
KRS 304.17A-661	Inpatient mental health and substance abuse must be in parity to sickness/illness coverage.			
KRS 304.17A-661	Outpatient mental health and substance abuse must be in parity to sickness/illness coverage.			
Prescription Drugs				

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

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	Allergy Tests			
Other				
	Private-Duty Nursing – must cover at least 250 – eight hour visits per year			
KRS 304.17-313	**Home Health Care Services –** must cover at least 100 visits per year. The minimum to be considered a visit is four (4) hours. **[preempts KY mandate]**			
	Skilled Nursing Facility – must cover at least 90 days per year			
	Inpatient Rehabilitation Facility – must cover at least 60 days per year.			
KRS 304.17A-132	**Hearing Aids** – one hearing aid per affected ear once every 36 months **[preempts KY mandate]**			
KRS 304.17A-141 KRS 304.17A-143 806 KAR 17:460 Advisory Opinion 2012-04	**Autism Spectrum Disorder** must cover as outlined in the 2017 Kentucky Benchmark **[Preempts KY mandate]**			
806 KAR 17:490 KRS 304.17A-250(6) Advisory Opinion 2014-04	**Hospice** - All health benefit plans must cover Hospice at least equal to Medicare benefits. **Cannot apply deductible unless the plan design is a High Deductible Health Plan with an HSA.** **Must provide same coverage in and out of network at same cost share. HMO plan designs must indicate on the schedule that the member has out-of-network coverage.**			
Preventive and wellness services				
	Preventive Services - Preventive services must be provided without cost sharing (no – co-payments, co-insurance or deductibles apply)– including the following:			
	Services recommended by the US Preventive Services Task Force with a rating of A or B **Check exclusions for conflicts with the recommendations.**			
	Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC **Check exclusions for conflicts with the recommendations.**			
	Preventive care & screenings for infants, children, & adolescents supported by the Health Resources & Services Administration **Check exclusions for conflicts with the recommendations.**			
KRS 304.17-3165 KRS 304.17A-135 KRS 304.17-316 KRS 304.17A-133 KRS 304.38-1935	Women's Preventive Care and Screenings including contraceptives, breast feeding support, sterilization procedures.			

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KRS 304.17-316(2)(b)	**Expanded Mammography** - Expanded mammogram coverage required for insureds of any age with a diagnosis of breast cancer must be included.			
KRS 304.17A-257	**Colorectal -** Coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines– **At no cost share.**			
Chronic Disease management and pediatric services, including oral and vision care				
KRS 304.17A-131	**Cochlear -** All plans shall provide coverage for cochlear implants for persons diagnosed with profound hearing impairment.			
KRS 304.17-3163 KRS 304.17A-134 KRS 304.38-1936	**Mastectomy/Endometrioses/Endometritis/Bone Density Testing -**For expense-incurred policies must provide coverage for medical surgical benefits for mastectomy, diagnosis and treatment of endometrioses and endometritis and bone density testing as outlined in the statute. Mastectomy coverage cannot be required to be on an outpatient basis.			
KRS 304.17A-136	**Cancer Clinical Trials coverage –** Health benefit plans cannot exclude coverage for routine patient healthcare costs that are incurred in the course of a cancer clinical trial as outlined in this statute.			
KRS 304.17A-148	**Diabetes -** Coverage for diabetes including equipment, supplies, outpatient self-management training, and education as outlined in this statute.			
KRS 304.17A-135 KRS 304.17-3165 KRS 304.38-1936	**Breast Cancer -** The mandated coverage for the treatment of breast cancer must be provided in accordance with the statute.			
KRS 304.17-319 806 KAR 17:090 KRS 304.38-1937	**TMJ** - The mandated coverage for treatment of Temporomandibular joint disorders (TMJ) and craniomandibular jaw disorders must be provided in accordance with the statute.			
2017 Kentucky Benchmark	**Pediatric Dental Services** (See 2017 Kentucky Benchmark Dental Checklist for specific benefits) **Coverage must be provided through the end of the month the member turns 21.**			
2017 Kentucky Benchmark	**Pediatric Vision Services** (See 2017 Kentucky Benchmark for specific benefits) ▪ Be limited to a recipient who is under age twenty-one (21) ▪ Must not exclude vision training and orthoptics ▪ One routine vision examination or refraction only in lieu of a complete exam per year ▪ One complete set of eyeglass frames and lenses per year, with one complete replacement set if medically necessary per year ▪ **One contact lens fitting and evaluation per year** ▪ One set of contacts per year (or the yearly equivalent) ▪ Only required to cover either eyeglasses or contacts not both. **Coverage must be provided through the end of the month the member turns 21.**			
Prohibited Provisions				

ACA STANDARDIZED OPTIONS BRONZE PLAN CHECKLIST

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

Statute/Rule	Description	Yes	No	Page #
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 KRS 304.17-030(7)	**Charter/By-laws** - The charter, bylaws or other constituent documents of the insurer should not be included in the policy **(Does not apply to Fraternal Benefit Society filings.)**			
KRS 304.17A-155 KRS 304.12-211	**Domestic Violence** – Cannot deny coverage, refuse to issue or renew, cancel or otherwise terminate, restrict, or exclude any person from a health benefit plan on the basis the person is a victim of domestic violence and abuse.			
KRS 304.14-370 KRS 304.14-380	**Jurisdiction of Courts/Venue of Suits** – All policies must comply with this statute.			
KRS 304.17A-138 806 KAR 17:270	**Telehealth Exclusion** - A Health Benefit Plan shall not exclude a service from coverage solely because the service is provided through Telehealth services.			
806 KAR 18:020 Section 2	**25% Differential for Non-HMO companies -** Health insurers cannot offer contracts containing preferred provider arrangements where the difference between amounts payable for preferred provider and a non-preferred provider exceed 25 percent. The Department's position on compliance with this regulation is the difference between copayments/coinsurances the member pays for out of network providers/services versus in-network providers/services is not greater than 25%. **If a non-HMO licensed entity offered a service as a in-network benefit there must be a corresponding out of network benefit.** Provider directories and plan information must be provided upon request.			
806 KAR 17:050	**Medicaid Eligibility** – Coverage cannot be limited, canceled, or deny coverage because a proposed insured is eligible for Medicaid			
Advisory Opinion 2010-01	**Discretionary Clauses** - The Department does not allow Discretionary Clauses in insurance policies.			
Catastrophic Plans				
Limitation	Catastrophic plans must meet all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. A catastrophic plan does not offer coverage at the bronze, silver, gold, or platinum coverage levels.			
Primary Care Visits	A catastrophic plan must provide at least three (3) primary care visits per year before reaching the deductible. Cost sharing can be imposed on these primary care visits unless they are for preventive care.			
Preventive Care	Preventive care must still be provided without cost share as outlined above in the ACA section.			
Deductible/Out of Pocket Maximum	The maximum Deductible/Out of Pocket Maximum for			

ACA STANDARDIZED OPTIONS BRONZE PLAN CHECKLIST

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Statute/Rule	Description	Yes	No	Page #
	2017: $7,150.00 for self-only coverage and $14,300.00 for other than self-only coverage. **2018: $7,350.00 for self-only coverage and $14,700.00 for other than self-only coverage.** All covered services including Essential Health Benefits are subject to the deductible except for the three (3) primary care visits and preventive care as outlined above.			
Eligible to Enroll	Catastrophic plans are limited to individuals younger than age 30 before the beginning of the plan year or those who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage (cost of coverage exceeds 8% of individual's household income for the taxable year – see IRS code 5000A(e)(1)) or they are eligible for a hardship exemption determined by HHS (see IRS code 5000A(e)(5)).			

***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.**