304.17A-505 Disclosure of terms and conditions of health benefit plan -- Filing with department.

An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health benefit plan and shall promptly provide the covered person and enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(1) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review;

2. An internal appeal of a utilization review made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit or the denial of payment for a health care service, and the procedure to initiate an internal appeal; and

3. An external review and the procedure to initiate the external review process;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the commissioner shall require by administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured or enrollee, a complete drug formulary; and

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer.

(2) The insurer shall file the information required under this section with the department.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1229, effective July 15, 2010. -- Amended 2000 Ky. Acts ch. 262, sec. 27, effective July 14, 2000; and ch. 500, sec. 2, effective July 14, 2000. -- Created 1998 Ky. Acts ch. 496, sec. 26, effective April 10, 1998.