Missouri Department of Insurance, Financial Institutions & Professional Registration
Insurance Market Regulation Division
Life & Healthcare Section
http://insurance.mo.gov/industry/filings/lh/index.php

Company Name: _____

Lead Form # as it appears in SERFF: _____

This form will be used in the following markets (please indicate all that apply):	
Large Group ☐	**Small Group** ☐

If the filing is used in a group or group type market, please indicate all that apply:			
Employer/(Single)Employer Trust; 376.421.1(1)	☐	Association; 376.421.1(5)	☐
Creditor; 376.421.1(2)	☐	Assoc. Sm. & Large Empl. 376.421.1(5)(e)	☐
Labor Union; 376.421.1(3)	☐	Credit Union; 376.421.1(6)	☐
Trust (MET, etc); 376.421(4)	☐	Discretionary; 376.421.2	☐

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Description of Provisions for Group Hospital/Surgical/Medical Expense or Major Medical

Type of Insurance (TOI) codes H15G and H16G

Subject	Citation	Summary	Location in Filing: Section &/or Page number required
Filing Submissions			
General Description	20 CSR 400-8.200(3)(C)	Brief, detailed description of benefits, purpose, and intended market. Disclose if form is new or a replacement. If amendment/rider, the policy it will go with.	
Filing Submissions	See Filing Guidelines 20 CSR 400-8.200	Procedures for filing all policy forms	
Separate Submissions	20 CSR 400-8.200(3)(E)&(F)	Life filed separate from health & group from individual.	
Form Number	20 CSR 400-8.200(3)(I)	Each form must have a form number assigned by the submitting company in the lower left corner of the face page or first page.	
Policy Forms			
Free Look	20 CSR 400-2.010(2)(A)	Only where member pays most or all of the premium: 10 day free look period	
Refund of Premium	20 CSR 400-2.010(2)(B)	Only where member pays most or all of the premium: refund of premium voids the policy from inception	

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C.O.B.	20 CSR 400-2.030	Coordination of benefits – group only	
C.O.B. – definition of plan type	20 CSR 400-2.030(2)(F)	The definition of "plan" must state the types of coverage considered in applying COB.	
C.O.B. – appendix	20 CSR 400-2.030(3)(B)	Appendix provided, certain changes permitted.	
C.O.B. – designation	20 CSR 400-2.030(3)(C)2	Plans may not designate themselves as always secondary	
C.O.B. – subrogation	20 CSR 400-2.030(6)(D)3	Subrogation will not be allowed in any plan as distinguished from the rights to recovery.	
Definitions	20 CSR 400-2.060(2)	Definitions for Hospital, Alcohol treatment facility, Intensive care unit	
Insured in the Military	20 CSR 400-2.060(3)(A)	If benefits are not provided for those who joined the military; pro-rata unearned refund; optional provision to re-instate at discharge	
Government hospital	20 CSR 400-2.060(3)(D)	Hospital reimbursement contracts not affected by confinement in government hospital	
Calculating benefits payable	20 CSR 400-2.060(3)(E)	Deductible shall be applied to allowable expenses prior to applicable coinsurance	
Prohibited language	20 CSR 400-2.060(3)(F)	Prohibits "accidental means" tests. Review Reg. for additional prohibited exclusions	
Alcoholism	20 CSR 400-2.060(3)(G)	Coverage for treatment of alcoholism – large groups refer to federal parity requirements	
Certificate - group	20 CSR 400-2.060(4)(A)	Certificate of Coverage to be delivered must be submitted for approval with master policy	
Variables	See Filing Guidelines	See Filing Guidelines	
Total Disability defined	20 CSR 400-2.060(4)(C)	Minimum standard for definition of Total Disability	
Residual Disability	20 CSR 400-2.060(4)(D)	Shall be defined in relation to the insured's reduction in earnings	
Suicide exclusion	20 CSR 400-2.060(4)(F)	May not exclude coverage for attempted suicide while insane	
Excluded occupational injuries	20 CSR 400-2.060(4)(G)	May exclude injuries arising in the course of employment	
Ambulatory Surgical Centers (ASCs)	20 CSR 400-2.060(6)	Services performed at a licensed ASC must be covered if such services are covered at inpatient hospitals and within the scope of the ASC's license; reimbursement to the ASC need not be the same as to the hospital	
Actual Payment	20 CSR 400-2.065	Insurers shall use the actual payment to providers as the basis for calculating cost participation amounts when such amounts are stated in the policy as a percentage.	
Conversion Privilege, group only	20 CSR 400-2.070	Conversion privilege must be offered as part of the policy	
HIV mandate	20 CSR 400-2.110	All forms shall cover HIV infection, including AIDS and ARC, as they would any other serious medical condition.	
Requirements for group health filings in-state and out-of-state	20 CSR 400-2.130(2)(C)&(3)	Affidavit requirements for all groups	

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Required definitions for speech and hearing disorders	20 CSR 400-2.140 See also 376.781	OFFER – definitions and terms of coverage	
Disclosure	375.924	Company address and telephone number	
Complications of pregnancy	375.995	Complications of pregnancy must be covered like any other covered illness;	
"Right of Recovery" (Maximum time to offset paid claims)	376.384.1(3)	Health carriers shall not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim.	
Chiropractic copayments	376.391	Copays limited to 50%. See also Bulletin 09-01.	
Grace period	376.426(1)	Grace period provision (31 days)	
Incontestability	376.426(2)	Validity of the policy shall not be contested after it has been in force for 2 years from date of issue	
Evidence of individual insurability	376.426(4)	Unless HIPAA protections apply, the conditions, if any, for which the insurer reserves the right to require evidence of insurability. See also 376.450	
Preexisting conditions	376.426(5)	Unless HIPAA protections apply, exclusions or limitations due to pre-existing conditions. See also 376.450	
Misstatement of age	376.426(6)	Amount of coverage to equal amount premium would have purchased at actual age at issue	
Certificate required	376.426(7)	Insurer shall deliver certificates of coverage	
Notice of claim	376.426(8)	Time frame to submit notice of claim	
Claim forms	376.426(9)	Insurer shall furnish forms for proof of loss within 15 days of request. Insured should be deemed to comply with requirements if company failures to furnish claim forms.	
Proof of loss due to disability	376.426(10)	Time limit for filing proof of loss	
Time benefits are payable	376.426(11)	Benefits payable within certain time frames (see also 376.383 and 376.384 for time to pay claims) and/or not less frequently than monthly	
To whom benefits are payable	376.426(12)	Benefits payable to beneficiary, estate, or minor.	
Exam/Autopsy	376.426(13)	Examination and autopsy at company expense	
Legal action	376.426(14)	No action at law prior to 60 days; within 3yrs	
Termination of policy	376.426(15)	Provision: conditions for which the policy may be terminated. HIPAA guaranteed renewability provisions also apply.	
Limiting age - handicapped children	376.426(16)	Dependents with disabilities will not be terminated if they attain limiting age and insured provides proof of incapacity	
Dependent coverage	376.426(17)	Coverage offered for eligible dependents who are no more than 25 years old	
Diabetes	376.385	OFFER – coverage of equipment, supplies and training for treatment of diabetes	

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Drug Co-pay	376.386	1 co-pay for multi dosage, where applicable	
Drug Cancellation Notification	376.392	30 days notice required before deleting a formulary drug – enrollee may request written notice	
Conversion – group	376.395-404	Conversion upon termination of eligibility – group – Notice of conversion rights shall be in the policy	
Newborn coverage	376.406	Moment of birth to 31 days. Plus an additional 10 days.	
Student accident policies may not limit surgical benefits	376.425	Student accident policies may not limit surgical procedures to 1 procedure if multiple procedures are done in one session.	
Continuation of coverage	376.428	Continuation for terminated member – group – Same as federal COBRA requirements	
Clinical Trials	376.429	Shall provide coverage for routine patient care costs incurred from phase II, III or IV clinical trials	
Claims incurred during the grace period	376.434	If policy automatically terminates for non-payment of premiums, carrier shall be liable for claims incurred during the grace period	
Extension of Benefits – group	376.438	Provision for extension of benefits in the event of total disability at the date of any termination	
Prior Carrier/Succeeding carrier	376.441 Bulletin 01-01	Coverage rights when changing plans	
Public Hospitals	376.778	Payment to public hospitals	
Speech & Hearing	376.781	OFFER – coverage speech and hearing impairments, cost-sharing comparable to other benefits	
Mammography	376.782	Coverage requirements, cost sharing requirements	
Child Health Supervision	376.801	OFFER – required services, cost-sharing requirements	
Elective abortions	376.805	Only as Optional Rider	
Coverage for adopted children	376.816	Provision identifying the effective dates of coverage for adoptive children, and coverage of pre-existing conditions	
Medicaid eligibility	376.818	Insurer may not take Medicaid eligibility or coverage into account when enrolling an individual or paying claims for the individual.	
Child Coverage: Discrimination Prohibited	376.820	Carriers may not deny coverage of a child because of marital status of parents, residence or income tax dependency claim.	
Effect of incarceration	376.821	Insurer may not cancel a policy solely because a person is incarcerated.	
Spousal continuation – group	376.891-894	Continued coverage after COBRA expires	
Direct access OB/GYN	376.1199	Direct access OB/GYN, Osteoporosis, Contraceptives	
Breast Cancer/ Chemotherapy	376.1200	OFFER – Treatments for breast cancer: Chemotherapy/Bone Marrow Transplants/Stem Cell	

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Reconstructive surgery following mastectomy	376.1209	Coverage for reconstructive surgery & prosthetic devices following mastectomy. No time limits allowed.	
Minimum maternity benefits	376.1210	CONTINGENT ON COVERAGE OF MATERNITY - 48/96 hr inpatient, post discharge services, notice required	
Childhood immunizations	376.1215	Childhood immunizations with no deductible or co-payment	
First Steps	376.1218	CONTINGENT on the company's choice to pay the assessment or cover benefits, company chooses annually – coverage for children enrolled in the Part C early intervention system.	
PKU testing and formula	376.1219	Coverage for formula and low protein food for PKU	
Newborn Hearing Screening	376.1220	Coverage for Newborn hearing screening, necessary re-screening, follow-up, initial amplification	
Coverage for hospital dental procedure	376.1225	Coverage for general anesthesia, hospital charges for dental care	
Coverage for Chiropractic Care	376.1230	Chiropractic care, no limits to the number of chiropractic service visits, but may require prior authorization after 26 visits	
Prosthetics	376.1232	OFFER – coverage of prosthetic devices and services, cost sharing requirements	
Cancer Screenings	376.1250	Pelvic exam, prostate exam, colorectal exam, comparable cost sharing	
Cancer Diagnosis- 2nd Opinion	376.1253	Patient has the right to a referral for a second opinion.	
Antigen Testing	376.1275	Antigen testing – comparable cost sharing, but benefit may be limited to $75	
Testing for lead poisoning	376.1290	OFFER – comparable cost sharing	
HIPAA requirements	376.450	Limits on pre-ex; requirements for special enrollment;	
Eligibility rules	376.451	Standards for eligibility and prohibiting discrimination	
Guaranteed renewability	376.452	Group policies guaranteed renewable; termination allowed only under specified conditions	

Mental Health / Chemical Dependency

Out-of-network visits	20 CSR 400-2.160	At least 2 out of network visits must be covered. For large groups, federal parity requirements also apply: out-of-network mental/chemical must equal out-of-network medical	
Alcoholism	376.779	Coverage for treatment of alcoholism; Large groups must comply with federal parity requirements	
Definitions	376.810	Definitions: chemical dependency & mental illness; mental illness coverage in group plans must comply with 376.1550	

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Chemical dependency	376.811	OFFER – limited applicability to chemical dependency only; mental illness coverage in group plans must comply with 376.1550	
Applied Behavioral Analysis (ABA)	376.1224	$40K+ coverage of ABA therapy, adjusted triennially for inflation	
Mental Health Mandate and Parity	376.1550	Coverage of all items in the DSM except drug/alchohol, on a parity basis, for all groups. Must be OFFERED for individual coverage. NOTE: Federal mental health parity also applies to large groups	

Grievance Procedures & Utilization Review

Definitions	376.1350	Definitions for utilization review and grievances	
Toll free #	376.1361.7	Timely access to review staff by a toll-free number	
Appeal for Drugs and DME	376.1361.10	Right to appeal for coverage of drugs & durable medical equip.	
Authorizations may not be retracted	376.1361.13	Authorization for services may not be reduced or retracted.	
UR Determinations	376.1363	Notification requirements for UR determinations and time frames	
Determination for emergency services	376.1367	No pre-auth for ER, prudent layperson std, post ER admit determinations	
Utilization Review procedures in EOC	376.1372	UR procedures in EOC	
Grievance procedures in EOC	376.1378	Includes statement that enrollee can contact DIFP at anytime; grievance procedure not a bar to law suits	
Grievance procedures	376.1382	Guidelines for 1st level grievance procedure identified;	
Grievance: second level review	376.1385	Guidelines for 2nd level grievance	
Expedited review	376.1389	Procedure for an expedited review	

Provisions applicable to small group only:

Eligible Employee	379.930.2(15)	Requirements for those who are eligible for coverage	
Late enrollee	379.930.2(23)	Provision for a late enrollee	
Definition of Small Employer	379.930.2(34)	2 to 50 employees.	
• Pre-existing condition exclusions • Qualifying previous coverage • Waiting periods	379.940.2(1)	See also 376.450 & 376.451 RSMo	
Participation Levels	379.940.2(2)	100% for groups 3 or less 75% for groups with more than 3 employees	

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Network Differentials

Actuarial Demonstration Differentials between in-network and non-network	375.936(11)(b)	Please provide the maximum difference in reimbursement levels between preferred and non-preferred providers. This information should include the maximum difference in deductibles, coinsurance and/or co-payments and lifetime maximum and may be given to our actuary for determination of compliance with 375.936(11)(b). If this information is identical to information provided in a previously approved filing, please provide the lead form number of that filing, the approval date, and the SERFF tracking number if you have it, as well as a certification that the information is identical to that of the previously approved filing.	

Prohibited provisions

"Sole Discretion"	376.405	Provisions that specifically state the company has sole discretionary power, or words to that effect, are not permitted
Ambiguous, misleading provisions	376.405	Policy provisions that are uncertain, ambiguous or not reasonably adequate for the protection of those insured will not be approved.
Arbitration	435.350	Arbitration is not allowed in contracts of insurance.
Force Majeure & Acts beyond the company control	376.405	Deemed as not reasonably adequate for the protection of the insured – not permitted.
Insert pages not permitted.	See Filing Guidelines 20 CSR 400-8.200	An insert Page cannot be filed.
Red-lined copies	20 CSR 400-8.200	Any redline copies are not approvable and must be placed on the SERFF "supporting documentation" area.
Rider a Rider	20 CSR 400-8.200(3)(D)	Companies may not "rider a rider", endorse and endorsement or amend an amendment.
Variable Language	20 CSR 400-2.060(4)(B)	Please see Filing Guidelines posted at http://insurance.mo.gov/industry/filings/lh/index.php
Variable Language - Blank pages	376.405	Brackets around an entire page constitute a "blank" or generic form – not permitted
Waiting Period	376.405	Waiting period during which no benefits are payable – not permitted

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