**STATE OF COLORADO**
**DEPARTMENT OF REGULATORY AGENCIES**

**DIVISION OF INSURANCE**
1560 Broadway, Suite 850
Denver, Colorado 80202

Amended Regulation 4-6-5

## CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS

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**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S.

**Section 2 Background and Purpose**

The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans.

**Section 3 Applicability and Scope**

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

**Section 4 Rules**

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] for Colorado".

2. Each small employer carrier shall title and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO)] Standard Health Benefit Plan for Colorado".

C. A small employer carrier shall actively market the basic and standard health benefit plans to small employers in this state.

D. In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic and standard health benefit plans.

E. Disclosure Statement

1. The following disclosure statement, prominently displayed in bold face capital letters no smaller than 14 point for printed materials or in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except the Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Insurance Regulation 4-2-20), small employer application forms, small employer renewal notices, and on all written refusals to insure that are related to health coverage for a business group of one.

   "Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2-50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during open enrollment periods as specified by law."

2. "Clear and conspicuous" means with respect to a disclosure that the disclosure is reasonably understandable and designed to call attention to the nature and

significance of the information it contains. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

a. Uses a typeface and type size that are easy to read;

b. Provides wide margins and ample line spacing;

c. Uses boldface, underscoring, capitals or italics for key words and phrases; and

d. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document and uses a type size that is greater than the type size predominantly used in the rest of the document or uses style and graphic devices, such as shading or sidebars.

3. If a disclosure is provided on a web page, the carrier must design its disclosure to call attention to the nature and significance of the information in it. For example, the carrier uses text or visual cues to encourage scrolling down the page, if necessary, to view the entire disclosure. The carrier must ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the disclosure, and the carrier either:

a. Places the disclosure on a screen that consumers frequently access, such as a page on which transactions are conducted; or

b. Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the disclosure and is labeled appropriately to convey the importance, nature and relevance of the disclosure.

F. Except as specified in §10-16-105.2(3), C.R.S., a small employer carrier shall offer the basic and standard health benefit plans along with all of its other small group plans to any small employer that applies for or makes an inquiry regarding health coverage from the small employer carrier. The offer may be provided directly to the small employer or delivered through a producer. The offer shall be in writing and shall include information as required by §10-16-105(5), C.R.S.

G. Quotes

1. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within five (5) business days of receiving all information necessary to provide a requested quote. Each price quote must be calculated using the carrier's filed rate, as defined in Colorado Insurance Regulation 4-6-7.

2. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) business days of receiving a request for a price quote if any additional information is needed. If a small employer carrier provides a price quote prior to receiving all information necessary to calculate any premium adjustments allowed under §10-16-105(8.5)(a), C.R.S., that quote must be the filed rate. The quote shall include a statement indicating that the rate is not final, and once all information is received, the rate will be recalculated using rating factors allowable by law, and may vary from the initial price quote.

3. A price quote shall be provided without requiring verification of the eligibility of the small group, including business groups of one. The fact that a price quote has been issued shall not prevent the small employer carrier from verifying the group's eligibility before issuing the coverage.

4. A small employer carrier shall not apply more stringent or detailed requirements related to the price quote or application process for the basic and standard health benefit plans than are applied for other small group health benefit plans offered by the small employer carrier, except as allowed for underwriting business groups of one.

5. Quotes for the basic and standard health benefit plans shall include quotes for each type of basic and standard health benefit plan the carrier markets (e.g., PPO, indemnity, HMO, HSA-qualified).

H. If a small employer carrier denies coverage to a business group of one for any of its health benefit plans on the basis of risk characteristics, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to the confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:

1. A general description of benefits contained in each such plan;

2. A price quote, in the manner required by Section 4.G. of this regulation, for each such plan if the business group of one is in its open enrollment period or a sample price quote reflecting current rates if the business group of one is not in its open enrollment period. In the case of a sample price quote, the small employer carrier shall disclose that the actual rates may be different than the sample rates if there are changes in the small employer carrier's filed rates or application of rating factors; and

3. Information describing how the business group of one can enroll in such plans. The explanation shall be provided directly to the business group of one or through an authorized producer within the time frames provided in Paragraphs G.1 and G.2.

I. A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or other such information that is reasonably designed to assist the caller to locate an authorized producer or otherwise apply for coverage through the carrier.

J. A small employer carrier may not require, as a condition for the offer or sale of a basic or standard health benefit plan, that the small employer purchase or qualify for any other product, service, or association.

K. A small employer carrier shall conform to the renewability requirements specified in §10-16-201.5, C.R.S.

L. Small employer carriers shall elicit, at the time of application, information from applicants necessary to determine whether or not small group laws apply pursuant to §10-16-105.2(1), C.R.S. If a small employer carrier fails to elicit this information it shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had done so.

M. Annual Report

1. A small employer carrier shall file annually, on a form specified by the Commissioner, information related to health benefit plans issued by the small employer carrier to small employers in this state. This information may include, but is not limited to:

    a. The number of small employers that were issued health benefit plans in the previous calendar year;

    b. The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year;

    c. The number of individuals issued coverage under small employer plans who were uninsured for at least three months prior to their effective date of coverage;

    d. The total number of individuals, separated as to employees and dependents, insured under basic and standard health benefit plans in the previous calendar year; and

    e. The total number of individuals, separated as to employees and dependents, insured under all small employer health benefit plans.

2. The information described in Paragraph M.1. shall be filed no later than March 1 of each year on the form specified by the Commissioner.

**Section 5 Enforcement**

Noncompliance with this regulation is a violation of §10-3-1104, C.R.S., and subject to the sanctions specified in §10-3-1108, C.R.S., including the imposition of fines and the suspension or revocation of the certificate of authority.

**Section 6 Severability**

If any provision of this regulation is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

**Section 7 Effective Date**

This amended regulation is effective on January 1, 2006.

**Section 8 History**

1 Original regulation effective January 1, 1995.
2 Amended regulation adopted recommended changes from Health Benefit Plan Advisory Committee to be effective January 1, 1996.
3 Emergency amendment to exclusion for work related illnesses and injuries effective January 1, 1996.
4 Amended regulation adopting emergency amendment as permanent effective April 1, 1996.
5 Amended regulation adopting recommended changes from the Health Benefit Plan Advisory Committee effective January 1, 1997.
6 Amended regulation incorporating changes required by 1997 legislation and recommendations of the Health Benefit Plan Advisory Committee effective January 1, 1998.
7 Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 1999.
8 Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2000.
9 Amended regulation, correcting errors in the Basic Indemnity Out-of-Pocket Maximum, the Basic PPO In-network Family Coinsurance, and the Standard Indemnity and PPO Maternity benefit. Corrections effective January 1, 2000.
10 Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2001.
11 Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2002.
12 Emergency regulation, effective January 1, 2003.
13 Amended regulation effective February 1, 2003.
14 Amended regulation effective January 1, 2004.
15 Emergency Regulation 04-E-4 effective July 1, 2004.
16 Emergency Regulation 04-E-9 effective September 29, 2004.

17 Amended regulation effective November 1, 2004.
18 Amended regulation effective January 1, 2006.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules and regulations related to those provisions, as they relate to small employer group plans, shall also apply.

4. Modifications to the basic and standard health benefit plans (unless specifically stated otherwise in statute) shall apply to any basic or standard plan, whether group or conversion, when issued or renewed on or after the effective date of the regulation specifying the change.

5. All basic and standard health benefit plans shall also comply with the following requirements:

   A. **Balance Billing:** In-network preferred providers and HMO providers are prohibited from balance billing individuals insured under the basic or standard health benefit plan. "Balance billing" refers to the practice whereby a provider bills an individual covered under the basic or standard health benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the services delivered.

      In the case of indemnity plans and out-of-network preferred provider plan benefits, carriers must alert those covered under the basic and standard health benefit plans to the fact that their provider is not prohibited from balance billing except as proscribed in §10-16-704, C.R.S. Consumers should be encouraged to discuss the issue with their provider.

   B. **Benefit Modifications:** The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only.

   C. **Cost Containment:** In their basic and standard health benefit plans, carriers shall disclose whether or not and to what extent they use or require the use of the following cost containment approaches: utilization review; second surgical opinions; pre-admission and pre-certification; use of non-physician primary care providers; alternative dispute resolution; and managed care. For preferred provider plans, accumulations for deductibles and out-of-pocket maximums are calculated separately for in-network and out-of-network. Carriers must disclose deductible and out-of-pocket maximum calculations on the Colorado Health Plan Description Form as required in Colorado Insurance Regulation 4-2-20.

      Use of gatekeepers is encouraged but not required. Carriers must offer the most managed care version of each indemnity, preferred provider, and/or HMO plan they offer in Colorado. A small employer carrier must offer the same choice of networks for its basic and standard plans as it offers for all its other small group health benefit plans (e.g., if a carrier markets to small employers both a PPO plan with a broad network and one with a limited network, it must provide basic and standard PPO options using each of the networks).

   D. **Eligibility:** "Actively at work" and "non-confinement" provisions are prohibited.

E. **Employer Contribution and Participation Requirements:** The employer contribution and participation requirements applied to the basic and standard plans shall be in compliance with §10-16-105(7.4), C.R.S.

F. **Enrollment:** To enroll an employee and dependents, the carrier shall require that:

1. Employers:
   a. Submit a written request for coverage;
   b. Provide information necessary to determine eligibility; and
   c. Agree to pay the required premium.

2. Eligible employees, on a form made available by the employer:
   a. Submit a written request for coverage for himself/herself and any dependents; and
   b. Provide information necessary to determine eligibility, if it is required.

G. **Family Planning Services:** Family planning services must be included as a covered benefit under both the basic and standard health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraception counseling.*

H. **Out-of-pocket Maximum:** All cost sharing (deductibles, coinsurance, copays), unless specifically noted otherwise, apply toward the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are paid at 100%. PPO non-network out-of-pocket maximum amounts are separate from the in-network out-of-pocket maximum amounts.

I. **Primary Care Providers:** Carriers may use non-physician providers, such as certified nurse practitioners and physician's assistants, as primary care providers under the basic and standard health benefit plans. However, carriers are not mandated to include non-physician providers.

J. **Copays:** All coverages that have any type of flat dollar copay are not subject to the deductible.

K. **Deductibles:** None of the basic and standard plans that include deductibles provide fourth quarter carryover credit. PPO non-network deductibles are separate from in-network deductibles.

L. **Usual, Customary and Reasonable Determinations:** For all basic and standard plans, each carrier shall use the same method of determining usual, customary and reasonable charge allowances as it uses for its most frequently sold non-basic, non-standard group health benefit plan in Colorado.

* Infertility treatment and counseling, and abortion services shall be covered by a carrier under the basic and standard health benefit plans if such services are covered by the carrier under its most frequently sold non-basic, non-standard group health plan in Colorado.

**[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Comprehensive Health Plan Description Form. However, it does *not* reflect full compliance with that form.]**

**All Colorado Small Group Health Insurance Companies**
Name of Carrier
**JANUARY 1, 2006 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO**
Name of Plan

## PART A: TYPE OF COVERAGE

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | BASIC HMO PLAN |
|---|---|---|---|
| 1. TYPE OF PLAN | Medical expense policy | Preferred provider plan | Health maintenance organization (HMO) |
| 2. OUT-OF-NETWORK CARE COVERED? [1] | Yes, policy makes no distinction between in- and out-of-network care. | Yes, but patient pays more for out-of-network care. | Only for emergency and urgent care. |
| 3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE | Plan is available throughout Colorado. | Varies by insurance company. | Varies by HMO. |

## PART B: SUMMARY OF BENEFITS

***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | | IN-NETWORK | OUT-OF-NETWORK [2] | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| 4. ANNUAL DEDUCTIBLE<br>*(Deductibles do not apply to benefits with flat dollar copays.)* | | | | |
| a) Individual | $ 3,000 | $ 3,000 | $ 6,000 | No deductible. |
| b) Family | $ 9,000 | $ 9,000 | $18,000 (Deductibles are separate from in-network deductibles) | No deductible. |

| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN IN-NETWORK | BASIC PREFERRED PROVIDER PLAN OUT-OF-NETWORK [2] | BASIC HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| **5. OUT-OF-POCKET ANNUAL MAXIMUM [3]**<br>*(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* | | | (Out-of pocket amounts are separate from in-network out-of-pocket amounts.) | |
| **a) Individual** | $ 11,000 | $ 6,000 excluding flat dollar copays | $ 12,000 | $ 6,000 |
| **b) Family** | $ 22,000 | $ 12,000 excluding flat dollar copays | $ 24,000 | $ 12,000 |
| **5A. COINSURANCE** (amount paid by carrier) **or COPAY** (amount paid by insured/member) | 50% coinsurance | 70% coinsurance | 50% coinsurance | Depends on the service, see details below. [4] |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | $1 million | $2 million | | No lifetime maximum. |
| **7A. COVERED PROVIDERS** | All providers licensed or certified to provide benefits. | List of covered in-network providers varies by insurance company. | All providers licensed or certified to provide benefits. | List of covered providers varies by HMO. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?** | Not applicable. This is not a network plan. | Answer varies by insurance company. | Not applicable. | Answer varies by HMO. |
| **8. ROUTINE MEDICAL OFFICE VISITS [5]** | | | | |
| **PCP** | 50% coinsurance | $40 copay/visit | 50% coinsurance | $40 copay/visit |
| **Specialist** | 50% coinsurance | $80 copay/visit | 50% coinsurance | $80 copay/visit |

| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN IN-NETWORK | BASIC PREFERRED PROVIDER PLAN OUT-OF-NETWORK [2] | BASIC HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| **9. PREVENTIVE CARE [6]** | For all plans, only specified preventive services are covered. | | | |
| **a) Children's services** (No deductible prior to application of coinsurance.) | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |
| **b) Adults' services [6a]** | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |
| **10. MATERNITY [7]** | 50% coinsurance | 70% coinsurance (1 PCP copay, then deductible and coinsurance apply to all other services) | 50% coinsurance | Applicable copays for type of service [8] |
| **11. PRESCRIPTION DRUGS [9]** *(Copays do not apply to out-of-pocket maximums.)* | $20 copay preferred generic; $50 copay preferred brand name $70 copay non-preferred [9a] | $20 copay preferred generic; $50 copay preferred brand name $70 copay non-preferred [9a] | | $20 copay preferred generic; $50 copay preferred brand name $70 copay non-preferred [9a] |
| **12. INPATIENT HOSPITAL** | 50% coinsurance | 70% coinsurance | 50% coinsurance | $500/day to $2,000 max per admission [10] |
| **13. OUTPATIENT/AMBULATORY SURGERY** | 50% coinsurance | 70% coinsurance | 50% coinsurance | $300 copay/visit[10a] |
| **14. DIAGNOSTICS [11]** | | | | |
| **a) Laboratory & X-ray** | 50% coinsurance | 70% coinsurance<br>If services are delivered as part of an office visit to the designated primary care provider, no additional copay or coinsurance requirement for lab & x-ray services applies. | 50% coinsurance | No copay |
| **b) MRI, Nuclear Medicine and Other High Tech Services** | 50% coinsurance | 70% coinsurance | 50% coinsurance | $200 copay |
| **15. EMERGENCY CARE [12, 13]** | 50% coinsurance | $250 copay then carrier pays 70% coinsurance *(No deductible)* | | $250 copay/visit [14] for in- and out-of-network emergency care. |
| **16. AMBULANCE** | 50% coinsurance | 70% coinsurance | 70% coinsurance | $100 copay |

| | **BASIC INDEMNITY PLAN** | **BASIC PREFERRED PROVIDER PLAN** | | **BASIC HMO PLAN** |
|---|---|---|---|---|
| **BASIC LIMITED MANDATE HEALTH BENEFIT PLAN** | | **IN-NETWORK** | **OUT-OF-NETWORK** [2] | **IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.) |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | 50% coinsurance | 70% coinsurance | 50% coinsurance | $100 copay/visit. *Out-of-network urgent care covered only if temporarily out of service area.* |
| **18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE** | For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan. | | | |
| **19. OTHER MENTAL HEALTH CARE**<br>**a) Inpatient care**<br>**b) Outpatient care** | Excluded | Excluded | | Excluded |
| **20. ALCOHOL AND SUBSTANCE ABUSE** | Excluded | Excluded | | Excluded |
| **21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [16]** | 50% coinsurance<br>**(Limited to 25 total visits/year)** | $40 copay<br>**(Limited to 25 total visits/year combined in and out-network)** | 50% coinsurance<br>**(Limited to 25 total visits/year combined in and out-network)** | $40 copay<br>**(Limited to 25 total visits/year)** |
| **22. DURABLE MEDICAL EQUIPMENT [17]** | 50% coinsurance<br>$1,000/year maximum | 70% coinsurance | 50% coinsurance | 20% copay<br>$1,000/year maximum |
| | | $1,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.) | | |
| **23. OXYGEN** | (Included under durable medical equipment) | (Included under durable medical equipment) | | (Included under durable medical equipment) |
| **24. ORGAN TRANSPLANTS [18]** | Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. | | | |
| | 50% coinsurance | 70% coinsurance | 50% coinsurance | Coverage is no less extensive than the coverage for any other physical illness. |
| **25. HOME HEALTH CARE** | Excluded | Excluded | Excluded | Excluded |
| **26. HOSPICE CARE** | Excluded | Excluded | Excluded | Excluded |

| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| 27. SKILLED NURSING FACILITY CARE [19] | 50% coinsurance (Not to exceed 100 days/year) | 70% coinsurance (Not to exceed 100 days/year) | 50% coinsurance (Not to exceed 100 days/year) | $50 copay/day (Not to exceed 100 days/year) |
| 28. DENTAL CARE | For all plans, not covered except for dental care needed as a result of an accident. | | | |
| 29. VISION CARE | No coverage | No coverage | No coverage | No coverage |
| 30. CHIROPRACTIC CARE | Excluded | Excluded | Excluded | Excluded |
| 31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5) | None | None | None | None |

## PART C: LIMITATIONS AND EXCLUSIONS

| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| 32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [20, 21] | Business Groups of One: 12 months for all pre-existing conditions<br>Business Groups of 2 – 50: 6 months for all pre-existing conditions | | | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| 33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy? | No. | No. | No. | No. |
| 34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"? | A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. | | | Not applicable. Plan does not exclude coverage for pre-existing conditions. |

| BASIC LIMITED MANDATE HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| **35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?** | Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war. | | | |

**1** "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

**2** Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network levels apply.

**3** "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under this basic plan, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

**4** However, notwithstanding the copay amounts listed in the Basic HMO Plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured exceed 50% of charges for any single service.

**5** Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

**6** See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

**6a** Prostate cancer screening and routine mammograms are not covered.

**7** Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

**8** The hospital copay applies to mother and well baby together; there are not separate copays.

**9** Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

**9a** Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

**10** Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

**10a** Copay includes all physician, facility services and supplies delivered during the visit.

**11** Includes diagnostic low dose mammography. (Routine mammography screenings not covered.)

**12** "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

**13** Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

**14** Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

**15** <u>"Biologically based mental illnesses"</u> means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

**16** Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age. The 25-visit limitation is not applied to children under 5 years of age for the purpose of providing therapy benefits pursuant to §10-16-102(1.7), C.R.S.

**17** Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

**18** Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

**19** Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

**20** <u>Waiver of pre-existing condition exclusions</u>. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had. The carrier or plan sponsor (e.g., employer) should provide details.

**21** The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

**22** Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

**[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Comprehensive Health Plan Description Form. However, it does *not* reflect full compliance with that form.]**

**All Colorado Small Group Health Insurance Companies**
Name of Carrier
**JANUARY 1, 2006 COLORADO BASIC HSA HEALTH BENEFIT PLANS**
**INDEMNITY, PREFERRED PROVIDER, AND HMO**
Name of Plan

## PART A: TYPE OF COVERAGE

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | BASIC HMO PLAN |
|---|---|---|---|
| 1. TYPE OF PLAN | Medical expense policy | Preferred provider plan | Health maintenance organization (HMO) |
| 2. OUT-OF-NETWORK CARE COVERED? [1] | Yes, policy makes no distinction between in- and out-of-network care. | Yes, but patient pays more for out-of-network care. | Only for emergency and urgent care. |
| 3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE | Plan is available throughout Colorado. | Varies by insurance company. | Varies by HMO. |

## PART B: SUMMARY OF BENEFITS

***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| **BASIC HSA HEALTH BENEFIT PLAN** | | **IN-NETWORK** | **OUT-OF-NETWORK[1a]** | **IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.) |
| **4. ANNUAL DEDUCTIBLE [2]** | ***For all plans, deductible applies to all services unless specifically noted.*** | | | |
| **a) Single Coverage** | $ 3,000 | $ 3,000 | $ 6,000 | $ 3,000 |
| **b) Non-Single Coverage** (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children) | $ 6,000 | $ 6,000 | $ 12,000<br>*(Deductibles are separate from in-network deductibles.)* | $ 6,000 |

| BASIC HSA HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN IN-NETWORK | BASIC PREFERRED PROVIDER PLAN OUT-OF-NETWORK[1a] | BASIC HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| **5. OUT-OF-POCKET ANNUAL MAXIMUM** [3]<br>*(Includes deductibles, coinsurance and copays.)* | | | *(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)* | |
| **a) Single Coverage** | $ 5,100 | $ 5,100 | $ 10,200 | $ 5,100 |
| **b) Non-Single Coverage** (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children) | $ 10,200 | $ 10,200 | $ 20,400 | $ 10,200 |
| **5A. COINSURANCE** (amount paid by carrier) **or COPAY** (amount paid by the insured/member) | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | $1 million | $2 million | | No lifetime maximum. |
| **7A. COVERED PROVIDERS** | All providers licensed or certified to provide benefits. | List of covered in-network providers varies by insurance company. | All providers licensed or certified to provide benefits. | List of covered providers varies by HMO. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?** | Not applicable. This is not a network plan. | Answer varies by insurance company. | Not applicable. | Answer varies by HMO. |
| **8. ROUTINE MEDICAL OFFICE VISITS** [4]<br>**PCP or Specialist** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **9. PREVENTIVE CARE** [5] | For all plans, only specified preventive services are covered. | | | |
| **a) Children's services** (No deductible) | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |
| **b) Adults' services** (No deductible) | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |

| BASIC HSA HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK[1a] | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| **10. MATERNITY [6]**<br>(Deductible, coinsurance, and copay percentage apply to all services.) | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **11. PRESCRIPTION DRUGS [7, 8]**<br>*(Deductible and out-of-pocket maximums apply.)* | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% copay |
| **12. INPATIENT HOSPITAL [9]** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **13. OUTPATIENT/AMBULATORY SURGERY** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **14. DIAGNOSTICS [10]** | | | | |
| **a) Laboratory & X-ray** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **b) MRI, Nuclear Medicine and Other High Tech Services** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **15. EMERGENCY CARE [11, 12]** | 50% coinsurance | 70% coinsurance<br>*(In-network deductible applies regardless of where service is provided.)* | | 30% copay |
| **16. AMBULANCE** | 50% coinsurance | 70% coinsurance | 70% coinsurance | 30% copay |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **18. BIOLOGICALLY BASED MENTAL ILLNESS [13] CARE** | For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan. | | | |

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| **BASIC HSA HEALTH BENEFIT PLAN** | | **IN-NETWORK** | **OUT-OF-NETWORK[1a]** | **IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.) |
| **19. OTHER MENTAL HEALTH CARE [14]**<br>**a) Inpatient care** | 50% coinsurance. Maximum 45 inpatient or 90 partial days/year. | 50% coinsurance. Maximum 45 inpatient or 90 partial days/year. | | 50% copay. Maximum 45 inpatient or 90 partial days/year. |
| **b) Outpatient care** | 50% coinsurance. Plan/Insurer pays a maximum of $1,000 per year. | 50% coinsurance. Plan/Insurer pays a maximum of $1,000 per year.<br><br>(In-network deductible applies to network providers and out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.) | | 50% copay. Plan pays a maximum of $1,000 per year. |
| **20. ALCOHOL AND SUBSTANCE ABUSE** | Acute detox: maximum 5 days per episode and 2 episodes per lifetime.<br><br>Covered at 50% coinsurance. | Acute detox: maximum 5 days per episode and 2 episodes per lifetime.<br>Covered at 50% coinsurance.<br><br>(In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.) | | Acute detox: maximum 5 days per episode and 2 episodes per lifetime.<br><br>Covered at 50% copay. |
| **21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [15]** | 50% coinsurance<br><br>**(Limited to 25 total visits/year)** | 70% coinsurance<br><br>**(Limited to 25 total visits/year combined in- and out-network)** | 50% coinsurance<br><br>**(Limited to 25 total visits/year combined in- and out-network)** | 30% copay<br><br>**(Limited to 25 total visits/year)** |
| **22. DURABLE MEDICAL EQUIPMENT[16]** | 50% coinsurance<br><br>$1,000/year maximum | 70% coinsurance | 50% coinsurance | 30% copay<br><br>$1,000/year maximum |
| | | $1,000/year maximum<br>(In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in- and out-of-network benefits.) | | |
| **23. OXYGEN** | (Included under durable medical equipment) | (Included under durable medical equipment) | | (Included under durable medical equipment) |
| **24. ORGAN TRANSPLANTS [17]** | Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. | | | |
| | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |

| BASIC HSA HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK[1a] | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| **25. HOME HEALTH CARE** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **26. HOSPICE CARE** [18] | 50% coinsurance per diem | 70% coinsurance per diem | 50% coinsurance per diem | 30% copay per diem |
| **27. SKILLED NURSING FACILITY CARE** [19] | 50% coinsurance (Not to exceed 100 days/year) | 70% coinsurance (Not to exceed 100 days/year) | 50% coinsurance (Not to exceed 100 days/year) | 30% copay (Not to exceed 100 days/year) |
| **28. DENTAL CARE** | For all plans, not covered except for dental care needed as a result of an accident. | | | |
| **29. VISION CARE** | No coverage | No coverage | No coverage | No coverage |
| **30. CHIROPRACTIC CARE** | Excluded | Excluded | Excluded | Excluded |
| **31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)** | None | None | None | None |

## PART C: LIMITATIONS AND EXCLUSIONS

| BASIC HSA HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| **32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [20, 21] | Business Groups of One: 12 months for all pre-existing conditions<br>Business Groups of 2 – 50: 6 months for all pre-existing conditions | | | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| **33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?** | No. | No. | No. | No. |
| **34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?** | A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. | | | Not applicable. Plan does not exclude coverage for pre-existing conditions. |

| BASIC HSA HEALTH BENEFIT PLAN | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| **35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?** | Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war. | | | |

**1** "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

**1a** Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

**2** "Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

**3** "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

**4** Routine medical office visits include physician, mid-level practitioner, and specialist visits including outpatient psychotherapy visits for biologically based mental illnesses.

**5** See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

**6** Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

**7** Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.

**8** Prescription drugs otherwise excluded are not covered.

**9** Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

**10** Includes diagnostic low dose mammography. Routine mammograms are covered.

**11** "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

**12** Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance applies.

**13** "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

**14** Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

**15** Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age. The 25-visit limitation is not applied to children under 5 years of age for the purpose of providing therapy benefits pursuant to §10-16-102(1.7), CRS.

**16** Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

**17** Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

**18** Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Insurance Regulation 4-2-8.

**19** Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

**20** Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had. The carrier or plan sponsor (e.g., employer) should provide details.

**21** The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

**22** Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

**[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Comprehensive Health Plan Description Form. However, it does *not* reflect full compliance with that form.]**

**All Colorado Small Group Health Insurance Companies**
Name of Carrier
**JANUARY 1, 2006 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS**
**INDEMNITY, PREFERRED PROVIDER, AND HMO**
Name of Plan

## PART A: TYPE OF COVERAGE

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | BASIC HMO PLAN |
|---|---|---|---|
| **1. TYPE OF PLAN** | Medical expense policy | Preferred provider plan | Health maintenance organization (HMO) |
| **2. OUT-OF-NETWORK CARE COVERED?** [1] | Yes, policy makes no distinction between in- and out-of-network care. | Yes, but patient pays more for out-of-network care. | Only for emergency and urgent care. |
| **3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE** | Plan is available throughout Colorado. | Varies by insurance company. | Varies by HMO. |

## PART B: SUMMARY OF BENEFITS

***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| **Basic HSA Limited Mandate Health Benefit Plan** | | **IN-NETWORK** | **OUT-OF-NETWORK**[1a] | **IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.) |
| **4. ANNUAL DEDUCTIBLE** [2] | ***For all plans, deductible applies to all services unless specifically noted.*** | | | |
| **a) Single Coverage** | $ 3,000 | $ 3,000 | $ 6,000 | $ 3,000 |
| **b) Non-Single Coverage** (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children) | $ 6,000 | $ 6,000 | $ 12,000 (Deductibles are separate from in-network deductibles) | $ 6,000 |

| Basic HSA Limited Mandate Health Benefit Plan | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN IN-NETWORK | BASIC PREFERRED PROVIDER PLAN OUT-OF-NETWORK[1a] | BASIC HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| **5. OUT-OF-POCKET ANNUAL MAXIMUM** [3] *(Includes deductibles, coinsurance and copays.)* | | | (Out-of pocket amounts are separate from in-network out-of-pocket amounts.) | |
| **a) Single Coverage** | $ 5,100 | $ 5,100 | $ 10,200 | $ 5,100 |
| **b) Non-Single Coverage** (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children) | $ 10,200 | $ 10,200 | $ 20,400 | $ 10,200 |
| **5A. COINSURANCE** (amount paid by carrier) **or COPAY** (amount paid by the insured/member) | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | $1 million | $2 million | | No lifetime maximum. |
| **7A. COVERED PROVIDERS** | All providers licensed or certified to provide benefits. | List of covered in-network providers varies by insurance company. | All providers licensed or certified to provide benefits. | List of covered providers varies by HMO. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?** | Not applicable. This is not a network plan. | Answer varies by insurance company. | Not applicable. | Answer varies by HMO. |
| **8. ROUTINE MEDICAL OFFICE VISITS** [4] | | | | |
| **PCP or Specialist** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **9. PREVENTIVE CARE** [5] | For all plans, only specified preventive services are covered. | | | |
| **a) Children's services** (No deductible) | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |
| **b) Adults' services** [5a] (No deductible) | 50% coinsurance | $40 copay/visit. | 50% coinsurance | $40 copay/visit. |

| Basic HSA Limited Mandate Health Benefit Plan | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN<br>IN-NETWORK | BASIC PREFERRED PROVIDER PLAN<br>OUT-OF-NETWORK[1a] | BASIC HMO PLAN<br>IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| **10. MATERNITY [6]**<br>(Deductible, coinsurance, and copay percentage apply to all services.) | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **11. PRESCRIPTION DRUGS [7, 8]**<br>*(Deductible and out-of-pocket maximums apply.)* | 50% coinsurance | 50% coinsurance | 50% coinsurance | 50% copay |
| **12. INPATIENT HOSPITAL [9]** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **13. OUTPATIENT/AMBULATORY SURGERY** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **14. DIAGNOSTICS [10]**<br>**a) Laboratory & X-ray** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **b) MRI, Nuclear Medicine and Other High Tech Services** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **15. EMERGENCY CARE [11, 12]** | 50% coinsurance | 70% coinsurance<br>(In-network deductible applies regardless of where service is provided.) | | 30% copay |
| **16. AMBULANCE** | 50% coinsurance | 70% coinsurance | 70% coinsurance | 30% copay |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **18. BIOLOGICALLY BASED MENTAL ILLNESS [13] CARE** | For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan. | | | |
| **19. OTHER MENTAL HEALTH CARE**<br>**a) Inpatient care**<br>**b) Outpatient care** | Excluded | Excluded | Excluded | Excluded |
| **20. ALCOHOL AND SUBSTANCE ABUSE** | Excluded | Excluded | Excluded | Excluded |

| | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| Basic HSA Limited Mandate Health Benefit Plan | | IN-NETWORK | OUT-OF-NETWORK[1a] | IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
| **21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY** [14] | 50% coinsurance **(Limited to 25 total visits/year)** | 70% coinsurance **(Limited to 25 total visits/year combined in- and out-network)** | 50% coinsurance **(Limited to 25 total visits/year combined in- and out-network)** | 30% copay **(Limited to 25 total visits/year)** |
| **22. DURABLE MEDICAL EQUIPMENT**[15] | 50% coinsurance $1,000/year maximum | 70% coinsurance | 50% coinsurance | 30% copay $1,000/year maximum |
| | | $1,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.) | | |
| **23. OXYGEN** | (Included under durable medical equipment) | (Included under durable medical equipment) | | (Included under durable medical equipment) |
| **24. ORGAN TRANSPLANTS** [16] | Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. | | | |
| | 50% coinsurance | 70% coinsurance | 50% coinsurance | 30% copay |
| **25. HOME HEALTH CARE** | Excluded | Excluded | Excluded | Excluded |
| **26. HOSPICE CARE** | Excluded | Excluded | Excluded | Excluded |
| **27. SKILLED NURSING FACILITY CARE** [17] | 50% coinsurance (Not to exceed 100 days/year) | 70% coinsurance (Not to exceed 100 days/year) | 50% coinsurance (Not to exceed 100 days/year) | 30% copay (Not to exceed 100 days/year) |
| **28. DENTAL CARE** | For all plans, not covered except for dental care needed as a result of an accident. | | | |
| **29. VISION CARE** | No coverage | No coverage | No coverage | No coverage |
| **30. CHIROPRACTIC CARE** | Excluded | Excluded | Excluded | Excluded |
| **31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)** | None | None | None | None |

## PART C: LIMITATIONS AND EXCLUSIONS

| Basic HSA Limited Mandate Health Benefit Plan | BASIC INDEMNITY PLAN | BASIC PREFERRED PROVIDER PLAN | | BASIC HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| **32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [18, 19]** | Business Groups of One: 12 months for all pre-existing conditions<br>Business Groups of 2 – 50: 6 months for all pre-existing conditions | | | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| **33. EXCLUSIONARY RIDERS**<br>**Can an individual's specific, pre-existing condition be entirely excluded from the policy?** | No. | No. | No. | No. |
| **34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?** | A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. | | | Not applicable. Plan does not exclude coverage for pre-existing conditions. |
| **35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?** | Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [20]; transplants except for those listed above; charges for surgical treatment of obesity; and war. | | | |

**1** "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

**1a** Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

**2** **"**Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

**3** "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

**4** Routine medical office visits include physician, mid-level practitioner, and specialist visits including outpatient psychotherapy visits for biologically based mental illnesses.

**5** See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

**5a** Prostate cancer screening and routine mammograms are not covered.

**6** Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

**7** Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.

**8** Prescription drugs otherwise excluded are not covered.

**9** Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

**10** Includes diagnostic low dose mammography. (Routine mammograms are not covered.)

**11** ”Emergency care” means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

**12** Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance applies.

**13** ”Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

**14** Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age. The 25-visit limitation is not applied to children under 5 years of age for the purpose of providing therapy benefits pursuant to §10-16-102(1.7), CRS.

**15** Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of all prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

**16** Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

**17** Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

**18** Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage insured/member recently may have had. The carrier or plan sponsor (e.g., employer) should provide details.

**19** The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

**20** Except that, if a workers’ compensation policy is in place (although not required by state labor law), the workers’ compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers’ compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO’s other small employer plans.

**[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Comprehensive Health Plan Description Form. However, it does *not* reflect full compliance with that form.]**

**All Colorado Small Group Health Insurance Companies**
Name of Carrier

**JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO**
Name of Plan

## PART A: TYPE OF COVERAGE

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | STANDARD HMO PLAN |
|---|---|---|---|
| **1. TYPE OF PLAN** | Medical expense policy | Preferred provider plan | Health maintenance organization (HMO) |
| **2. OUT-OF-NETWORK CARE COVERED?** [1] | Yes, policy makes no distinction between in- and out-of-network care. | Yes, but patient pays more for out-of-network care. | Only for emergency and urgent care. |
| **3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE** | Plan is available throughout Colorado. | Varies by insurance company. | Varies by HMO. |

## PART B: SUMMARY OF BENEFITS

***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | |
| **4. ANNUAL DEDUCTIBLE** *(Deductibles do not apply to benefits with flat dollar copays.)* | | | | |
| **a) Individual** | $ 1,500 | $ 1,500 | $ 3,000 | No deductible. |
| **b) Family** | $ 4,500 | $ 4,500 | $ 9,000 (Deductibles are separate from in-network deductibles) | No deductible. |

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | |
| **5. OUT-OF-POCKET ANNUAL MAXIMUM** [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)* | | | (Out-of-pocket amounts are separate from in-network out-of-pocket amounts.) | |
| **a) Individual** | $ 2,500 | $ 3,000 excluding flat dollar co-pays | $ 6,000 | $ 3,000 |
| **b) Family** | $ 7,500 | $ 6,000 excluding flat dollar co-pays | $ 12,000 | $ 6,000 |
| **5A. COINSURANCE** (amount paid by carrier) **or COPAY** (amount paid by insured/member) | 80% coinsurance | 80% coinsurance | 50% coinsurance | Depends on the service, see details below. [4] |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | $1 million | $2 million | | No lifetime maximum. |
| **7A. COVERED PROVIDERS** | All providers licensed or certified to provide benefits. | List of covered in-network providers varies by insurance company. | All providers licensed or certified to provide benefits. | List of covered providers varies by HMO. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?** | Not applicable. This is not a network plan. | Answer varies by insurance company. | Not applicable. | Answer varies by HMO. |
| **8. ROUTINE MEDICAL OFFICE VISITS** [5] | | | | |
| **PCP** | 80% coinsurance | $25 copay/visit | 50% coinsurance | $25 copay/visit |
| **Specialist** | 80% coinsurance | $40 copay/visit | 50% coinsurance | $40 copay/visit |
| **9. PREVENTIVE CARE** [6] | For all plans, only specified preventive services are covered. | | | |
| **a) Children's services** (No deductible prior to application of coinsurance.) | 80% coinsurance | $25 copay/visit | 50% coinsurance | $25 copay/visit |
| **b) Adults' services** | 80% coinsurance | $25 copay/visit | 50% coinsurance | $25 copay/visit |

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | |
| **10. MATERNITY [7]** | 80% coinsurance<br>Deductible and coinsurance apply | 80% coinsurance<br>(1 PCP copay then deductible and coinsurance for all other charges) | 50% coinsurance | Applicable copays for type of service. [8] |
| **11. PRESCRIPTION DRUGS [9]**<br>*(Copays do not apply to out-of-pocket maximums.)* | $10 copay preferred generic;<br>$30 copay preferred brand name<br>$50 copay non-preferred [9a] | $10 copay preferred generic;<br>$30 copay preferred brand name<br>$50 copay non-preferred [9a] | $10 copay preferred generic;<br>$30 copay preferred brand name<br>$50 copay non-preferred [9a] | $10 copay preferred generic;<br>$30 copay preferred brand name<br>$50 copay non-preferred [9a] |
| **12. INPATIENT HOSPITAL** | 80% coinsurance | 80%coinsurance | 50% coinsurance | $250/day to a max of $1,000 per admission [10] |
| **13. OUTPATIENT/AMBULATORY SURGERY** | 80% coinsurance | 80% coinsurance | 50% coinsurance | $100 copay/visit [10a] |
| **14. DIAGNOSTICS [11]** | | | | |
| **a) Laboratory & X-ray** | 80% coinsurance | 80% coinsurance<br>If services are delivered as part of an office visit to the designated primary care provider, no additional copay or coinsurance requirement for lab & x-ray services applies. | 50% coinsurance | No copay for physician-ordered services. |
| **b) MRI, Nuclear Medicine and Other High Tech Services** | 80% coinsurance | 80% coinsurance | 50% coinsurance | $100 copay |
| **15. EMERGENCY CARE [12, 13]** | 80% coinsurance | $125 copay then plan pays 80% coinsurance | | $125 copay/visit [14] for in- and out-of-network emergency care. |
| **16. AMBULANCE** | 80% coinsurance | 80% coinsurance | | $100 copay |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | 80% coinsurance | 80% coinsurance | 50% coinsurance | $75 copay/visit.<br>Out-of-network urgent care covered only if temporarily traveling out of service area. |

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | |
| **18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE** | For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan. | | | |
| **19. OTHER MENTAL HEALTH CARE [17]** | | | | |
| **a) Inpatient care [16]** | 50% coinsurance<br>Maximum 45 inpatient or 90 partial days/year | 50% coinsurance<br>Maximum 45 inpatient or 90 partial days/year | | 50% copay<br>Maximum 45 inpatient or 90 partial days/year |
| **b) Outpatient care** | 50% coinsurance<br>Plan/insurer pays maximum $1,500/year | 50% coinsurance<br>Plan/insurer pays maximum $1,500/year | | 50% copay<br>Plans pay maximum 20 visits or $1,500/year |
| **20. ALCOHOL AND SUBSTANCE ABUSE** | Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18] | Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18] | | Diagnosis, medical treatment & referral services. 50% copay.[19] |
| **21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]** | 80% coinsurance<br>**(Limited to 25 total visits/year)** | 80% coinsurance<br>**(Limited to 25 total visits/year combined in and out-network)** | 50% coinsurance<br>**(Limited to 25 total visits/year combined in and out-network)** | $25 copay<br>**(Limited to 25 total visits/year)** |
| **22. DURABLE MEDICAL EQUIPMENT [21]** | 80% coinsurance<br>$2,000/year maximum | 80% coinsurance | 50% coinsurance | 20% copay<br>$2,000/year maximum |
| | | $2,000/year maximum<br>(In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.) | | |
| **23. OXYGEN** | (Included under durable medical equipment) | (Included under durable medical equipment) | | (Included under durable medical equipment) |
| **24. ORGAN TRANSPLANTS [22]** | Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. | | | |

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN IN-NETWORK ONLY (Out-of-network care is not covered except as noted.) |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK [2] | |
| *(ORGAN TRANSPLANTS continued)* | 80% coinsurance | 80% coinsurance | 50% coinsurance | Coverage is no less extensive than the coverage for any other physical illness. |
| **25. HOME HEALTH CARE** | 80% coinsurance | 80% coinsurance | 50% coinsurance | No copay (100% covered) |
| **26. HOSPICE CARE [22a]** | 80% coinsurance per diem | 80% coinsurance per diem | 50% coinsurance per diem | No copay (100% covered) |
| **27. SKILLED NURSING FACILITY CARE[23]** | 80% coinsurance (Not to exceed 100 days/year) | 80% coinsurance (Not to exceed 100 days/year) | 50% coinsurance (Not to exceed 100 days/year) | $50 copay/day (Not to exceed 100 days/year) |
| **28. DENTAL CARE** | For all plans, not covered except for dental care needed as a result of an accident. | | | |
| **29. VISION CARE** | No coverage | No coverage | No coverage | No coverage |
| **30. CHIROPRACTIC CARE** | No [See 31(1)] | No [See 31(1)] | No [See 31(1)] | No [See 31(1)] |
| **31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)**<br>**(1) Spinal manipulation** | 80% coinsurance | 80% coinsurance | 50% coinsurance | $25 copay |

## PART C: LIMITATIONS AND EXCLUSIONS

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| **32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [24, 25]** | Business Groups of One: 12 months for all pre-existing conditions<br>Business Groups of 2 – 50: 6 months for all pre-existing conditions | | | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| **33. EXCLUSIONARY RIDERS Can an individual's specific, pre-existing condition be entirely excluded from the policy?** | No. | No. | No. | No. |

| | STANDARD INDEMNITY PLAN | STANDARD PREFERRED PROVIDER PLAN | | STANDARD HMO PLAN |
|---|---|---|---|---|
| | | IN-NETWORK | OUT-OF-NETWORK | |
| 34. **HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?** | A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy. | | | Not applicable. Plan does not exclude coverage for pre-existing conditions. |
| 35. **WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?** | Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war. | | | |

**1** "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

**2** Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

**3** "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

**4** However, notwithstanding the copay amounts listed in this Standard HMO Plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured exceed 50% of charges for any single service.

**5** Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.

**6** See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

**7** Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

**8** The hospital copay applies to mother and well baby together; there are not separate copays.

**9** Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

**9a** Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

**10** Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

**10a** Copay includes all physician, facility services and supplies delivered during the visit.

**11** Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, §10-16-104(4), C.R.S.

**12** ”Emergency care” means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

**13** Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

**14** Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

**15** ”Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

**16** The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

**17** Pursuant to §10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to §10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of §10-16-105(2), C.R.S., relating to such an exclusion.

**18** Carriers shall also offer alcoholism coverage pursuant to §10-16-104(9), C.R.S., as may be amended.

**19** HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101 (a)(5).

**20** Coverage for medically necessary therapeutic treatment only - benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age.

**21** Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

**22** Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

**22a** Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Regulation 4-2-8.

**23** Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

**24** Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had. The carrier or plan sponsor (e.g., employer) should provide details.

**25** The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

**26** Except that, if a workers’ compensation policy is in place (although not required by state labor law), the workers’ compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers’ compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO’s other small employer plans.

## Attachment 1

| Covered Preventive Services [1] | |
|---|---|
| All Persons | 1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer. |
| | Chicken pox vaccination for all persons who have not had chicken pox. |
| All Children | Immunizations.<br>Immunization deficient children are not bound by “recommended ages”. |
| Age 0-12 months | 1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. |
| | 5 well-child visits [2] |
| | 1 PKU |
| Age 13-35 months | 2 well-child visits |
| Age 3-6 | 3 well-child visits |
| Age 7-12 | 3 well-child visits |
| Age 13-18 | 1 age appropriate health maintenance visit [3] every year |
| | 1 Td |
| | Females: screening pap smears not to exceed 1 per year |
| | 1 hepatitis B vaccination if not given previously |

**1** Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans.

**2** "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

**3** “Age appropriate health maintenance visit” means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

| | |
|---|---|
| Age 19-39 | 1 Td every ten years |
| | 1 age appropriate health maintenance visit every three years |
| | 1 fasting lipid panel |
| | Females ages 35-39: 1 baseline screening mammogram and clinical breast exam<br>(***Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.***) |
| | Females: screening pap smears not to exceed 1 per year |
| Age 40-64 | 1 Td every ten years |
| | 1 fasting lipid panel every five years |
| | Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75 |
| | 1 age appropriate health maintenance visit every 24 months |
| | Females ages 40-49: 1 screening mammogram and clinical breast exam every 2 years (annually, if high risk)<br>(***Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.***) |
| | Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months<br>(***Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.***) |
| | Females: screening pap smears not to exceed 1 per year |
| | Males: Prostate screening as specified in state law<br>(***Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.***) |
| Age 65 and older | 1 influenza immunization every year |
| | 1 pneumococcal vaccine at or after age 65 |
| | Females: screening pap smears not to exceed 1 per year |
| | 1 Td every ten years |
| | 1 age appropriate health maintenance visit every year |
| | Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months |
| | Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75 |
| | Males: Prostate screening as specified in state law<br>(***Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.***) |