

# STATE OF COLORADO

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**DEPARTMENT OF REGULATORY AGENCIES**

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## Bulletin 11-05

### Concerning the Colorado Health Plan Description Form For the Standard Indemnity, Standard Preferred Provider, and Standard HMO Small Group Health Benefit Plans, For Use with the Sale of Individual Policies to Business Groups of One

Issued: October 28, 2005

#### I. Background and Purpose

The purpose of this bulletin is to provide a sample of the health benefit plan description form for the Colorado Standard Health Benefit Plans as required by Section 10-16-105.2(1)(c)(I)(D), C.R.S. This bulletin provides the form for the Standard Health Benefit Plans that will be in use as of January 1, 2006. This bulletin should be used in place of Bulletin 01-05.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

#### II. Applicability and Scope

This bulletin applies to all carriers marketing or selling individual health benefit plans to self-employed business groups of one.

#### III. Division Position

- A. Carriers may obtain a copy of the Colorado Health Plan Description Form for the small group Standard Indemnity, Preferred Provider, and Health Maintenance Organization plans for each calendar year by writing or calling the Division of Insurance, or via the internet:

Standard Health Plan Description Form  
Rates and Forms Section  
Colorado Division of Insurance  
1560 Broadway, Suite 850  
Denver, CO 80202  
Tel. 303-894-7499  
Internet: <http://www.dora.state.co.us/insurance>

*"The Mission of the Division of Insurance is Consumer Protection."*

General Number: (303) 894-7499 / Consumer Complaints: (303) 894-7490 / Toll Free 1-800-930-3745 / FAX: (303) 894-7455

Producer Licensing/ASI: 1-800-275-8247 / V/TDD for the Deaf or Hearing Impaired: (303) 894-7880

<http://www.dora.state.co.us/insurance>

B. Carriers are reminded that the coverage provided by the Standard Health Benefit Plans may change each calendar year, as provided for in law. Carriers should make sure they are using the most up-to-date description form for the Standard plans.

1. The description form to be used for 2006 is attached to this bulletin.
2. Each year the Division of Insurance will make available the description form for the following year's Standard Health Benefit Plans if any changes have been made.

#### **IV. For More Information**

For more information, contact:

Dayle Axman

Tel. 303-894-7881

E-mail: [dayle.axman@dora.state.co.us](mailto:dayle.axman@dora.state.co.us)

**COLORADO HEALTH PLAN DESCRIPTION FORM**

**All Colorado Small Group Health Insurance Companies**

Name of Carrier

**2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO**

Name of Plan

**PART A: TYPE OF COVERAGE**

	<b>STANDARD INDEMNITY PLAN</b>	<b>STANDARD PREFERRED PROVIDER PLAN</b>	<b>STANDARD HMO PLAN</b>
<b>1. TYPE OF PLAN</b>	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
<b>2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup></b>	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.
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	Plan is available throughout Colorado.	Varies by insurance company.	Varies by HMO.

**PART B: SUMMARY OF BENEFITS**

**Important Note:** This form is not a contract; it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	<b>STANDARD INDEMNITY PLAN</b>	<b>STANDARD PREFERRED PROVIDER PLAN</b>		<b>STANDARD HMO PLAN</b>
		<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK <sup>3</sup></b>	<b>IN-NETWORK ONLY</b> (Out-of-network care is not covered except as noted.)
<b>4. ANNUAL DEDUCTIBLE <sup>2</sup></b> <i>(Deductibles <u>do not</u> apply to benefits with flat dollar copays.)</i>				
<b>a) Individual</b>	\$ 1,500	\$ 1,500	\$ 3,000	No deductible.
<b>b) Family (Aggregate deductibles.)</b>	\$ 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	OUT-OF-NETWORK <sup>3</sup>	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>4</sup></b>  <i>(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)</i>				
<b>a) Individual</b>	\$ 2,500 (includes deductible and coinsurance)	\$ 3,000 (excluding flat dollar co-pays)	\$ 6,000	\$ 3,000
<b>b) Family</b>	\$ 7,500 (includes deductibles and coinsurance)	\$ 6,000 (excluding flat dollar co-pays)	\$ 12,000	\$ 6,000
<b>c) Is deductible included in the out-of-pocket maximum?</b>	Yes	Yes	Yes	Yes
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$1 million	\$2 million		No lifetime maximum.
<b>7A. COVERED PROVIDERS</b>	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.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Not applicable. This is not a network plan.	Answer varies by insurance company.	Not applicable.	Answer varies by HMO.
<b>8. ROUTINE MEDICAL OFFICE VISITS<sup>5</sup></b>				
<b>Primary Care Providers</b>	20% coinsurance	\$25 copay/visit	50% coinsurance	\$25 copay/visit
<b>Specialist</b>	20% coinsurance	\$40 copay/visit	50% coinsurance	\$40 copay/visit
<b>9. PREVENTIVE CARE</b>	For all plans, only specified preventive services are covered.			
<b>a) Children's services</b> (No deductible prior to application of coinsurance.)	20% coinsurance	\$25 copay/visit	50% coinsurance	\$25 copay/visit
<b>b) Adults' services</b>	20% coinsurance	\$25 copay/visit	50% coinsurance	\$25 copay/visit



	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK <sup>3</sup>	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance	20% coinsurance	50% coinsurance	\$75 copay/visit. Out-of-network urgent care covered only if temporarily traveling out of service area.
18. BIOLOGICALLY BASED MENTAL ILLNESS <sup>15</sup> 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 <sup>16</sup>  a) Inpatient care <sup>17</sup>  b) Outpatient care	50% coinsurance Maximum 45 inpatient or 90 partial days/year  50% coinsurance Plan/insurer pays maximum \$1,500/year	50% coinsurance Maximum 45 inpatient or 90 partial days/year  50% coinsurance Plan/insurer pays maximum \$1,500/year		50% copay Maximum 45 inpatient or 90 partial days/year  50% copay 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. <sup>18</sup>	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance. <sup>18</sup>		Diagnosis, medical treatment & referral services. 50% copay. <sup>19</sup>
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY <sup>20</sup>	20% coinsurance  (Limited to 25 total visits/year)	20% 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)	\$25 copay  (Limited to 25 total visits/year)
22. DURABLE MEDICAL EQUIPMENT <sup>21</sup>	20% coinsurance  \$2,000/year maximum	20% coinsurance  \$2,000/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.)	50% coinsurance	20% copay  \$2,000/year maximum
23. OXYGEN	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK <sup>3</sup>	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
<b>24. ORGAN TRANSPLANTS<sup>22</sup></b>	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.			
	20% coinsurance	20% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.
<b>25. HOME HEALTH CARE</b>	20% coinsurance	20% coinsurance	50% coinsurance	No copay (100% covered)
<b>26. HOSPICE CARE<sup>23</sup></b>	20% coinsurance per diem	20% coinsurance per diem	50% coinsurance per diem	No copay (100% covered)
<b>27. SKILLED NURSING FACILITY CARE<sup>24</sup></b>	20% coinsurance (Not to exceed 100 days/year)	20% coinsurance (Not to exceed 100 days/year)	50% coinsurance (Not to exceed 100 days/year)	\$50 copay/day (Not to exceed 100 days/year)
<b>28. DENTAL CARE</b>	For all plans, not covered except for dental care needed as a result of an accident.			
<b>29. VISION CARE</b>	No coverage	No coverage	No coverage	No coverage
<b>30. CHIROPRACTIC CARE</b>	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]
<b>31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)</b>				
(1) Spinal manipulation	20% coinsurance	20% 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	
<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED<sup>25</sup></b>	Business Groups of One: 12 months for all pre-existing conditions Business Groups of 2 – 50: 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
<b>33. EXCLUSIONARY RIDERS</b> Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	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.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	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 <sup>26</sup> ; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

**PART D: USING THE PLAN**

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	Yes	No	Yes
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	No	Yes	No	Yes
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	Yes	No	Yes	No
<b>39. What is the main customer service number?</b>	[Main customer service number varies depending on which carrier you are covered by]			
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?</b>	[Whom you write/call varies depending on which carrier you are covered by.]			

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Contact: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202 Email: Insurance@dora.state.co.us Fax: 303-894-7455			
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	This is a small group plan. [Form number varies depending on which carrier you are covered by.]			
43. Does the plan have a binding arbitration clause?	Answer varies by carrier.			

- 1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers are used (i.e., go in-network) than if you don't (i.e., go out-of-network).
- 2 "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.
- 3 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.
- 4 "Out-of-pocket maximum" refers to the maximum amount you 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 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.
- 5 Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses.
- 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 The hospital copay applies to mother and well baby together; there are not separate copays.
- 8 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.
- 9 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred. 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.
- 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 that 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 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.
- 17 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.
- 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.
- 23 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.
- 24 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.
- 25 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 you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
- 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.