Regulation 4-1-1 Variable Annuity Contracts

I. Authority

This regulation is promulgated pursuant to the authority of § § 10-1-109 and 10-7-405, C.R.S.

II. Purpose

The purpose of this regulation is to amend existing Regulation 4-1-1 (3 CCR 702-4) and to establish the standards and limitations for variable annuity contracts issued by insurers authorized for such sales in Colorado.

III. Scope

This regulation is applicable to all insurance companies and fraternal benefit societies delivering or issuing for delivery in Colorado variable annuity contracts providing for payments which vary directly according to investment experience of any separate account or accounts maintained by the insurer as provided in § 10-7-402, C.R.S.

IV. Separate Accounts

A. The company shall maintain in each such separate account assets with a market value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the Commissioner.

B. Rules under any provision of the insurance law of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to member; of any separate account's committee, board or other similar body.

C. Reserve liabilities for the variable aspects of the variable annuity contracts shall be maintained in the separate account and established under the standards of Part 3 of Article 7 of Title 10, C.R.S., in accordance with actuarial procedures that recognize the variable nature of the benefits provided. The reserve liabilities shall be limited to the market value of the assets in the separate account.

D. Except with specific prior written authorization from the Commissioner, any guaranteed contract benefit in a variable annuity contract must be purchased from, and reserved in, the general account, with the appropriate transfer of sufficient cash or cash equivalent funds for the risk being transferred.

E. To the extent provided in the variable annuity contract, that portion of the assets of any separate account which is equal to the reserves and other contract liabilities shall not be subject to creditor claims against the insurer.

V. Contracts Providing For Variable Benefits

A. Any variable annuity contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate of evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience. Such contract or certificate shall contain on its first page a clear statement, in type at least as large as that used for text matter, to the effect that the benefits thereunder are on a variable basis. The contract benefits shall reflect the investment and expense experience, positive or negative, of separate accounts) established and maintained by the insurer for such contracts. The

allocation and determination of the variable benefits derived from such experience must be actuarially sound and shall not exceed the total separate account assets.

B. Illustrations of benefits payable under any variable annuity contract shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits.

C. No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which in the opinion of the Commissioner are more favorable to the holders of such contracts.

1. A provision that there shall be a grace period of not less than 30 days within which any stipulated payment to the insurer may be made. During such grace period the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the grace period shall be applied to produce the values under the contract arising therefrom;

2. A provision that, at any time within three years from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom;

3. A provision specifying the options available in the event of default in a periodic stipulated payment. Such options may include an option to surrender the contract for a cash value as determined by the contact, and shall include an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of such paid-up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract; and

4. A provision specifying that only the contract, application, and any documents attached thereto constitute the entire contract.

VI Required Reports

A. Any company issuing individual variable annuity contracts shall mail to the contract holder at least once in each contract year at his last address known to the company, a statement or statements reporting he investments held in the separate account

B. in the case of a variable annuity contract under which payments have not yet commenced, any company issuing individual variable annuity contracts shall mail to the contract holder at least once in each contract year at his last address known to the company, a statement as of a date not more than four months previous to the date of mailing that reports: (1) the number of accumulation units credited to such contract and the dollar value of a unit, or (2) the value of the contract holder's account

VII Foreign or Alien Companies

If the law or regulation in the place of domicile of a foreign or alien company provides protection to the policy holders and the public which is substantially equal to that provided by Colorado statutes and

regulations, the Commissioner may consider compliance with such laws or regulations as compliance with Colorado laws and regulations. The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purpose of this regulation.

VIII Statutory Construction

Pursuant to the provisions of § 10-7-405, CRS, the provisions of the Colorado Insurance Laws applicable to annuity contracts shall apply to variable annuity contracts.. This includes, but is not limited to, custodial arrangements of separate account assets, unfair methods of competition and deceptive acts or practices, annual reporting, and appropriate contract requirements contained in Parts 1 and 3 of Article 7 of Tittle 10, C.R.S. In addition, all federal laws and regulations governing variable life policies shall apply.

IX. Severability

If any provision of this regulation or the application thereof to any person or circumstance is; for any reason held to be invalid, the remainder of the regulation and the application of such provision to other person or circumstances shall not be affected thereby.

X. Effective Date

This regulation is effective July 1, 1994.

Amended Regulation 4-1-2 Advertising and Sales Promotion of Life Insurance

Section 1. Authority

This amended regulation is promulgated under the authority of § § 10-1 -108(8), 10-1 -109 and 10- 3-

1110, Colorado Revised Statutes (C.R.S.).

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

Section 3. Scope

A. This regulation shall apply to any life insurance or annuity advertisement intended for dissemination in this state. In variable contracts where disclosure requirements are established pursuant to federal regulation, this regulation shall be interpreted so as to eliminate conflict with federal regulation.

B. All advertisements, regardless of by whom written, created or presented the advertisement. Insurers shall establish and, at all times, maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. A system of control shall include regular and routine notification, at least once a year, to producers, brokers and others authorized by the insurer to disseminate advertisements of the requirement and procedures for company approval prior to the use of any advertisements that is not furnished by the insurer and that clearly sets forth within the notice the most serious Consequence of not obtaining the required prior approval.

Section 4. Definitions

A. “Advertisement” means material designed to create public interest in life insurance or annuities or in an insurer, or in an insurance producer; or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy including:

(1) Printed and published material, audiovisual material and descriptive literature of an insurer or insurance producer used in direct mail, newspapers, magazines, radio and television scripts, telemarketing scripts, billboards, posters and similar displays, and the Internet or any other mass communication media.

(2) Descriptive literature and sales aids of all kinds, authored by the insurer, its insurance producers or third parties, issued, distributed or used by such insurer or insurance producer, including but not limited to circulars, leaflets, booklets, depictions, web pages, illustrations, form letters, and lead-generating devices of all kinds;

(3) Material used for the recruitment, training and education of an insurer's insurance producers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, and

(4) Prepared sales talks, presentations and material for use by insurance producers.

B. “Advertisement” for the purpose of these rules shall not include:

(1) Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(2) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(3) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a

booklet explaining the proposed coverage.

C. “Determinable policy elements” means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non- interest based credits, charges or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable policy elements only, or from both determinable and guaranteed policy elements.

D. “Guaranteed policy element” means the premiums, benefits, values, credits or charges under a policy, or elements of formulas used to determine any of these that are guaranteed and determined at issue.

E. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

F. “Insurer” means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an “insurer” in the insurance code of this state or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

G. “Lead-generating device” means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of life insurance policies and annuity contracts.

H. “Policy” means any policy, plan, certificate, including a fraternal benefit certificate, contract, agreement, statement of coverage, rider or endorsement which provides for life insurance or annuity benefits.

I. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

J. “Preneed funeral contract or prearrangement” means an arrangement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Form and Content of Advertisements

A. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

B. No advertisement shall use the terms “investment,” “investment plan,” “founder's plan,” “charter plan,” “deposit,” “expansion plan,” “profit,” “profits,” “profit sharing,” “interest plan,” “savings,” “savings plan,” “private pension plan,” “retirement plan” or other similar terms in connection with

a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

Section 6. Disclosure Requirements

A. The information required to be disclosed by this regulation shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

B. An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied or that the policy or contract includes a "free look" period that satisfies or exceeds regulatory requirements, does not remedy misleading statements.

C. In the event an advertisement uses "non-medical," "no medical examination required," or similar terms where issue is not guaranteed, terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions set forth in the application.

D. An advertisement shall not use as the name or title of a life insurance policy any phrase that does not include the words "life insurance" unless accompanied by other language clearly indicating it is life insurance. An advertisement shall not use as the name or title of an annuity contract any phrase that does not include the word "annuity" unless accompanied by other language clearly indicating it is an annuity. An annuity advertisement shall not refer to an annuity as a CD annuity, or deceptively compare an annuity to a certificate of deposit.

E. An advertisement shall prominently describe the type of policy advertised.

F. An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no insurance producer or commission involved there will be a cost saving to prospective purchasers unless that is the fact. No cost savings may be stated or implied without justification satisfactory to the commissioner prior to use.

G. An advertisement for a life insurance policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, that fact shall be commonly disclosed. An advertisement of or for a life insurance policy under which the death benefit varies with the length of time the policy has been in force shall accurately describe and clearly call attention to the amount of minimum death benefit under the policy.

H. An advertisement for the types of policies described in subsections F and G of this section shall not use the words "inexpensive," "low cost," or other phrases or words of similar import when such policies are being marketed to persons who are fifty years of age or older, when the policies being marketed are guaranteed issue.

I. Premiums

(1) An advertisement for a policy with non-level premiums shall prominently describe the premium changes.

(2) An advertisement in which the insurer describes a policy where :.t reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.

(3) An advertisement shall not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

(4) An advertisement that represents that a pure endowment benefit has a “profit” or “return” on the premium paid, rather than a policy benefit for which a specified premium is paid is deemed to be deceptive and misleading and is prohibited.

(5) An advertisement shall not represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact.

(6) An advertisement shall not use the term “Vanish” or “Vanishing premium,” or a similar term that implies the policy becomes paid up, to describe a plan using nonguaranteed elements to pay a portion of future premiums.

J. Analogies between a life insurance policy or annuity contract's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments shall be complete and accurate. An advertisement shall not emphasize the investment or tax features of a life insurance policy to such a degree that the advertisement would mislead the purchaser to believe the policy is anything other than life insurance.

K. An advertisement shall not state or imply in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or improper practice.

L. If nonforfeiture values are shown in any advertisement, the values must be shown either for the entire amount of the basic life policy death benefit or for each $1,000 of initial death benefit.

M. The words” free,” “no cost,” “without cost,” “no additional cost, “at no extra cost,” or words of similar import shall not be used with respect to any benefit or service being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor shall be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

N. No insurance producer may use terms such as “financial planner,” “investment adviser,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is generally engaged in an advisory business in which compensation is unrelated to sales unless that actually is the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

O. Nonguaranteed Elements

(1) An advertisement shall not utilize or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead.

(2) An advertisement shall not state or imply that the payment or amount of nonguaranteed elements is guaranteed. Unless otherwise specified in Colorado Regulation 4-1-8, if nonguaranteed elements are illustrated, they shall be based on the insurer's current scale and the illustration shall contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

(3) Unless otherwise specified in Colorado Regulation 4-1-8, an advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth, with equal prominence comparable illustrations or statements containing or based upon the guaranteed policy elements.

(4) An advertisement shall not use or describe determinable policy elements in a manner that is misleading or has the capacity or tendency to mislead.

(5) Advertisement may describe determinable policy elements as guaranteed but not determinable at issue. This description should include an explanation of how these elements operate, and their limitations, if any.

(6) If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way; such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation on the insurer's right.

(7) An advertisement shall not refer to dividends as “tax-free” or use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.

(8) An advertisement may not state or imply that illustrated dividends under either or both a participating policy or pure endowment will be or can be sufficient at any future time to assure without the future payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains the benefits or coverage provided at that time and the conditions required for that to occur.

P. An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

Q. Testimonials, Appraisals, Analysis, or Endorsements by Third Parties

(1) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective insureds as to the nature or scope of the testimonial, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis; the insurer or insurance producer makes as its own all the statements contained therein, and these statements are subject to all the provisions of this regulation.

(2) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the insurer or related entity as a stockholder, director, officer, employee or

otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(4) When an endorsement refers to benefits received under a policy for a specific claim, the claim date, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of five (5) years after the discontinuance of its use or publication.

R. An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any statistics used in advertisement shall be identified.

S. Policies Sold to Students

(1) The envelope in which insurance solicitation material is contained may be addressed to the parents of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student unless such is a correct and truthful statement.

(2) All advertisements including, but not limited to, informational flyers used in the solicitation of insurance shall be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities shall be clearly identified as such.

(3) The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.

T. Introductory, Initial or Special Offers and Enrollment Periods

(1) An advertisement of an individual policy or combination of policies shall not state or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not describe an enrollment period as “special” or “limited” or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(2) An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(3) An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. A reduced initial or first year premium may not be described as constituting free insurance for a period of time. When insurer charges an initial premium that differs in

amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the' full rate schedule for the policy being advertised.

(4) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date on which the enrollment period is advertised for the first time. This regulation applies to all advertising media-i.e., mail, newspapers, radio, television, magazines and periodicals-by any one insurer or insurance producer. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control. This regulation does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his or her request. It is also inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specified provisions of the insurance code for group, blanket or franchise insurance. In cases where insurance product is marketed on a direct mail basis to prospective insurance by reason of some common relationship with a sponsoring organization, this regulation shall be applied separately to each sponsoring organization.

U. An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group, or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless that is the fact.

V. An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.

W. For individual deferred annuity products or deposit funds, the following shall apply:

(1) Any illustrations or statements containing or based upon nonguaranteed interest rates shall likewise set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The nonguaranteed interest rate shall not be greater than those currently being credited by the Company unless the nonguaranteed rates have been publicly declared by the company with an effective date for new issues not more than three (3) months subsequent to the date of declaration.

(2) If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it shall also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.

(3) If the contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning the contract shall prominently state that cash surrender benefits are not provided.

(4) Any illustrations, depictions or statements containing or based on determinable policy elements shall likewise set forth with equal prominence comparable illustrations, depictions or statements containing or based on guaranteed policy elements.

X. An advertisement of a life insurance policy or annuity that illustrates nonguaranteed values shall only do so in accordance with current applicable state law relative to illustrating such values for life insurance policies and annuity contracts.

Y. An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement as defined in Section 4F that is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

(1) The fact that a life insurance policy or annuity contract is being used to fund a prearrangement as defined in Section 4F; and

(2) The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise services, the administrator and any other person.

Section 7. Identity of Insurer

A. The name of the insurer shall be clearly identified in all advertisements about the insurer or its products, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. However, if an advertisement contains a listing of rates or features that is a composite of several different policies or contracts of different insurers, the advertisement shall so state, shall indicate, if applicable, that not all policies or contracts on which the composite is based maybe available in all states, and shall provide a rating of the lowest rated insurer and reference the rating agency, but need not identify each insurer. If an advertisement identifies the issuing insurers, insurance issuer ratings need not be stated.

B. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, a reinsurer of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

C. An advertisement shall not use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with a governmental program or agency.

Section 8. Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement may state that an insurer or insurance producer is licensed in a particular state or states, provided it does not exaggerate that fact or suggest or imply that competing insurers or insurance producers may not be so licensed.

C. An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

Section 9. Statements About the Insurer

An advertisement shall not contain statements, pictures or illustrations that are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation including, but not limited to, the placement of insurer's rating in the hierarchy of the rating system cited.

Section 10. Enforcement Procedures

A. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies, hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to inspection by the department. All advertisements shall be maintained in the file for a period of five (5) years after discontinuance of its use or publication.

B. If the commissioner determines that an advertisement has the capacity or tendency to mislead or deceive the public, the commissioner may require an insurer or insurance producer to submit all or any part of the advertising material for review or approval prior to use.

Section 11. Enforcement

Failure to comply with this regulation is considered an unfair or deceptive trade practice pursuant to § 10-3-1104, Colorado Revised Statutes (C.R.S.). Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license.

Section 12. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 13. Effective Date

This regulation as amended is effective March 1,2003.

Section 14. History

Originally issued as Regulation 74-5, effective March 15,1974.

Amended Regulation, effective July 1,1976.

Renumbered as Regulation 4-1-2, effective June 1,1992.

Repealed and Repromulgated in full, effective July 1,2001.

Amended Regulation, effective March 1,2003.

Regulation 4-1-3 Variable Life Insurance Policies

I Authority

The following regulations applicable to variable life insurance policies are promulgated under the authority

of § § 10-1-109 and 10-7-405, C.R.S.

II. PURPOSE

The purpose of this regulation is to amend existing Colorado Insurance Regulation 4-1-3 (3 CCR 702-4) and to establish the standards and limitations for variable life insurance policies issued by insurers authorized for such sales in Colorado.

III. SCOPE

This regulation is applicable to alt insurance companies and fraternal benefit societies delivering or issuing for delivery in this state variable life insurance policies providing for payments which vary directly according to investment experience of any separate account or accounts maintained by the insurer as provided in § 10-7-402, C.R.S. This regulation does not apply to variable annuity contracts, which are regulated pursuant to Colorado Insurance Regulation 4-1-1 (3 CCR 702-4).

IV. DEFINITIONS

As used in this regulation:

"Assumed investment rate" means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses and mortality and all other charges and expenses to maintain the variable death benefit equal at all times to the amount of death benefit other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account. For the purposes of this calculation, the deductions for expense charges shall be at the maximum rate permitted in the policy.

"Benefit base" means the amount to which the net investment return is applied. "Flexible Premium Policy" means any variable life insurance policy other than a scheduled premium policy as specified in this section.

"General account" means all assets of the insurer other than assets in separate accounts established pursuant to § 10-7-402, C.R.S., or pursuant to the corresponding section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

"Incidentalinsurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability income benefits, guaranteed insurability options, family income, or term riders.

"Minimumdeath benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

"Netinvestment return" means the rate of investment return in a separate account to be applied to the benefit base.

"Person" means an individual, corporation, partnership, association, trust, or fund.

"Policyprocessing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

"Scheduledpremium policy" means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

"Separate account" means a separate account established pursuant to § 10-7-402, C.R.S., or pursuant to the corresponding section of the Insurance Laws of the state of domicile of a foreign or alien insurer.

"Variabledeath benefit" means the amount of death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

"Variablelife insurance policy" means any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to § 10-7-402, C.R.S.

V. STANDARDS OF SUITABILITY

Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the Standards of Suitability to be used by the insurer. These Standards shall include procedures to assure that the sales of variable products are not unsuitable for applicants on the basis of information furnished, after reasonable inquiry of such applicants concerning their insurance and investment objectives, financial situation and needs, and taking into account any other information known to the insurer or to the agent (any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent) making the recommendation.

VI. INSURANCE POLICY REQUIREMENTS

A. Mandatory Policy Benefit and Design Requirements:

Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements:

1. the policy benefits shall reflect the investment and expense experience, positive or negative, of separate accounts) established and maintained by the insurer for such policies. The allocation and determination of the variable benefits derived from such experience must be actuarially sound and shall not exceed the total separate account assets;

2. each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base;

3. any change(s) in variable death benefits of each variable life insurance policy shall be determined at least annually; and

4. the cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other nonforfeiture benefits, as described in the policy shall be in accordance with generally accepted actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other nonforfeiture benefits must be at least equal to the minimum values required by Part 3, Article 7 of Title 10, C.R.S. for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under Part 3 of Article 7 of Title 10, C.R.S. If the policy does not state an assumed investment rate, this demonstration shall be based on the maximum interest rate permitted under Part 3 of Article 7 of Title 10, C.R.S.

B. Applications:

The application for a variable life insurance policy shall contain:

1. a prominent statement in either contrasting color or in boldface type that the death benefit may be variable or fixed under specified conditions;

2. a prominent statement in either contrasting color or in boldface type that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

3. questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant

C. Mandatory Policy Provisions:

Every variable life insurance policy shall contain at least the following:

1. the cover page or pages corresponding to the cover page of each such policy shall contain:

    a. a prominent statement in either contrasting color or in boldface type that the amount or duration of death benefit, cash values or other nonforfeiture benefits may be variable or fixed under specified conditions which may include minimum guarantees;

    b. a statement describing any guaranteed minimum benefit;

    c. the method, or a reference to the policy provision, which describes the method for determining the amount of insurance payable at death;

    d. such other items as are currently required for fixed benefit life insurance policies and which are appropriate for the policy and not inconsistent with this regulation.

2. a provision for a grace period as follows:

    a. for scheduled premium policies, a provision for a grace period of not less than thirty-one days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date; and

    b. for flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the Report to Policyholders required by section (VIII)(3) of this regulation.

        The death benefit payable during me grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing day falls within the grace period, the insurer may require the payment of not more than 3 times the charges due on that policy processing day, but only for those charges which are necessary to keep such policy in force until the next policy processing day.

3. for scheduled premium policies, a. provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

    a. all overdue premiums with interest at a rate not exceeding six percent (6%) per annum compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding eight percent (8%) per annum compounded annually; or

    b. one hundred ten percent (110%) of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding six percent (6%) per annum compounded annually;

4. a full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

5. a provision designating the separate accounts) to be used and stating that:

    a. the assets of such separate account(s) shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account;

    b. the assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly;

6. a provision specifying that only the policy, application, and any documents attached thereto constitute the entire insurance policy;

7. a designation of the officers of the insurer who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representations and not warranties;

8. an identification of the owner of the insurance policy,

9. a provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in Ae absence of a beneficiary designation;

10. a statement of any conditions or requirements concerning the assignment of the policy;

11. description of any adjustments in policy values to be made in me event of misstatement of age or sex of the insured;

12. a provision that the policy shall be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's; insurability, shall be incontestable after any such increase has been in force, during the lifetime of the insured, for two years from the date of issue of

such increase;

13. a provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

    a. for up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account; or

    b. otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical;

14. if settlement options are provided, at least one such option shall be on a fixed basis;

15. a description of the basis for computing the cash value and the surrender value under the policy shall be included;

16. premiums or charges for insurance benefits with incidental insurance benefits stated separately;

17. any other policy provisions required by this regulation;

18. such other items as are currently required for fixed benefit life insurance policies which are appropriate for the policy and are not inconsistent with this regulation; and

19. if the investment policy of the separate account is materially changed, a provision giving policyholders the right to convert, without evidence of insurability, to an alternate plan in the separate or general account.

D. Policy Loan Provisions:

Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain a provision for policy loans after the policy has been in force for 2 full years which provides the following:

1. at least 75% of the policy's cash surrender value may be borrowed;

2. the amount borrowed shall bear interest at a rate consistent with the Colorado Notice dated 5-1-82, “Life Insurance Policy Loan Interest Rates/Guidelines,” available from the Chief of Corporate Affairs, Colorado Division of Insurance;

3. any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit;

4. for scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within thirty-one days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policyholder which contains the information specified by section (VIII)(3) of this regulation;

5. the policy may provide that if, at any time so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request;

6. the policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision;

7. no policy loan provision is required if the policy is under extended term insurance nonforfeiture option; and

8. amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment.

E. Policy Guarantee Provisions:

Except with specific prior written authorization from the Commissioner, any guaranteed policy benefit in a variable life insurance policy must be purchased from, and reserved in, the general account, with the appropriate transfer of sufficient cash or cash equivalent funds for the risk being transferred.

F. Other Policy Provisions:

The following provisions may in substance be included in a variable life insurance policy or related form delivered or issue for delivery in this state:

1. an exclusion for suicide within one year of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within one year of any increase in death benefits which results from an application of the owner subsequent to the policy issue date;

2. policies issued on a participating basis shall offer to pay dividend amounts in cash, [n addition, such policies may offer dividend options available under general account products.

3. a provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under subsection (D) of this section of this regulation, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

4. a provision allowing the policyholder to make partial withdrawals; and

5. any other policy provision approved by the Commissioner.

VII. INFORMATION FURNISHED TO APPLICANTS

An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this section shall be deemed to have been satisfied to the extent that a disclosure containing information required by this section is delivered, either in the form of (1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or (2) all

information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to section 3(aX2) thereof.

1. A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation.

2. A statement of the investment policy of the separate account, including:

    a. a description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

    b. any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted.

3. A statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence.

4. A statement of the charges levied against the separate account during the previous year.

5. A summary of the method to be used in valuing assets held by the separate account.

6. A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder, and the beneficiary.

7. Illustrations of benefits payable under the variable life insurance policy. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

VIII. REPORTS TO POLICYHOLDERS

Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

1. within 30 days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, and any optional payments allowed pursuant to section (VI)(D) of this regulation under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within thirty days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty days prior to the mailing of such notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report must show the

projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that: (a) planned periodic premiums, if any, are paid as scheduled; (b) guaranteed costs of insurance are deducted; and (c) the net investment return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid;

2. annually, a statement or statements including:

    a. a summary of the financial statement of the separate account based on the annual statement last filed with the Commissioner,

    b. the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

    c. a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the Commissioner,

    d. any charges levied against the separate account during the previous year, and

    e. a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment adviser of the separate account.

3. For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

IX. RESERVE LIABILITIES FOR VARIABLE LIFE INSURANCE POLICIES

1. Reserve liabilities for the variable aspects of the variable life insurance policies shall be maintained in the separate account and established under Part 3 of Article 7 of Title 10, C.R.S., in accordance with actuarial procedures that recognize the variable nature of the benefits provided. The reserve liabilities shall be limited to the market value of the assets of the separate account.

2. Reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in (he general account of the insurer and shall be not less than the greater of the following minimum reserve:

    a. the aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance policy; or

    b. the aggregate total of the “attained age level” reserve on each variable life insurance policy. The “attained age level” reserve on each variable life insurance policy shall not be less than zero and shall equal the “residue,” as described in

subsection (2)(b)(i) of this section of this regulation, of the prior year's “attained age level” reserve on the policy, with any such “residue” increased or decreased by a payment computed on an attained age basis as described in subsection (2)(b)(n) of this section of this regulation.

i. The “residue” of the prior year's “attained age level” reserve on each variable life insurance policy shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the “excess,” if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The “excess” referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

ii. The payment referred to in subsection (2)(b)of this section of this regulation shall be computed so that the present value of a level payment of that amount each year over the future premium paying period for the policy is equal to (a) minus (b) minus (c), where (a) is the present value of the future guaranteed minimum death benefits, (b) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (c) is any “residue,” as described in subsection (2)(b)(i) of this section of this regulation, for the prior year's “attained age level” reserve on such variable life insurance policy. The amounts of future death benefits referred to in subsection (2Xb) of this section of this regulation shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life insurance policies.

c. the valuation interest rate and mortality table used in computing the two minimum reserves described in subsections (2Xa) and (2Xb) of this section of this regulation shall conform to permissible standards for the valuation of life insurance policies. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

3. Except with specific prior written authorization from the Commissioner, any guaranteed policy benefit in a variable life insurance policy must be purchased from, and reserved in, the general account, with the appropriate transfer of sufficient cash or cash equivalent funds for the risk being transferred.

X. SEPARATE ACCOUNTS

The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer:

A. Establishment and Administration of Separate Accounts:

Any domestic insurer issuing variable life insurance policies shall establish one or more separate accounts pursuant to § 10-7-402, C.R.S.

1. All persons with access to the cash, securities, or other assets of the separate account shall be under bond in an amount as prescribed in Colorado Insurance Regulation 3-1-1 3 CCR 702-3.

2. The assets of such separate accounts shall be invested in investments having a reasonably ascertainable market value with such market value determined at least as often as variable benefits are determined but in any event at least monthly.

3. To the extent provided in the policies, that portion of the assets of any separate account which is equal to the reserves and other policy liabilities shall not be subject to creditor claims against the insurer.

B. Amounts in the Separate Account:

The insurer shall maintain in each separate account assets with a value at least equal 10 the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

C. Charges Against a Separate Account:

1. The insurer must disclose in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account, including, but not limited to the following:

   a. taxes or reserves for taxes attributable to investment gains and income of the separate account;

   b. actual cost of reasonable brokerage fees and similar direct acquisitions and sales costs incurred in the purchase or sale of separate account assets;

   c. charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account; and

   d. other risk charges not directly paid by the policy owner.

D. Conflicts of Interest:

Rules under any provision of the Insurance Laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

E. Investment Advisory Services to a Separate Account:

1. An insurer shall not enter into a policy under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless such investment advisory policy shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment adviser.

2. The Commissioner may, after notice and opportunity for hearing, by order require such investment advisory policy to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

XI. FOREIGN OR ALIEN COMPANIES

If the law or regulation in the place of domicile of a foreign or alien company provides protection to the policy holders and the public which is substantially equal to that provided by Colorado statutes and regulations, the Commissioner may consider compliance with such laws or regulations as compliance with Colorado laws and regulations. The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purpose of this regulation.

XII. Statutory Construction

Except as provided by § 10-7-405, C.R.S., the provisions of the Colorado Insurance Laws applicable to life insurance policies shall apply to variable life insurance policies. This includes, but is not limited to, custodial arrangements of separate account assets, unfair methods of competition and deceptive acts or practices, annual reporting, and appropriate policy requirements contained in Parts 1 and 3 of Article 7 of Title 10, C.R.S. In addition, all federal laws and regulations governing variable life insurance policies shall apply.

XIII. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other person or circumstances shall not be affected thereby.

XIV. Effective Date

This regulation is effective July 1,1994.

Repromulgated Regulation 4-1-4 Replacement Of Life Insurance Policies And Annuities

Section 14. History

Appendix A. Important Notice Regarding Replacements

Appendix B. Notice Regarding Replacements for Direct Response Insurers

Appendix C. Important Notice Regarding Replacements for Direct Response Insurers

Section 1. Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-3-1110(1). Colorado Revised Statutes (C.R.S.).

Section 2. Purpose

A. The purpose of this regulation is:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.

(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

(a) Assure that purchasers receive information with which a decision can be made in his or her own best interest;

(b) Reduce the opportunity for misrepresentation and incomplete disclosure; and

(c) Establish penalties for failure to comply with requirements of this regulation.

Section 3. Scope

A. This regulation shall apply to life insurance policies and annuity contracts covering residents of this state, which are solicited and issued by insurance corporations, fraternal benefit societies, associations or other institutions, which issue life insurance or annuities.

B. Unless otherwise specifically included, this regulation shall not apply to transactions involving:

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of Section 9;

(3) Group life insurance and annuities used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant, to a program filed with the commissioner,

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6)

(a) Policies or contracts used to fund (i) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (ii) a plan described by Sections 401 (a), 401 (k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer; (iii) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(b) Notwithstanding Subparagraph (a), this regulation shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two (2) or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(7) Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member,

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five (5) years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this regulation; or

(10) Structured settlements.

C. Registered contracts shall be exempt from the requirements of Sections 7A(2) and 8B with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

Section 4. Definitions

A. “Direct-response solicitation” means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

B. “Existing insurer” means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of “replacement.”

C. “Existing policy or contract” means an individual life insurance policy (policy) or annuity contract

(contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

D. “Financed purchase” means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four (4) months before or thirteen (13) months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in Section 6A(5) of this regulation.

E. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in Colorado Regulation 4-1-8.

F. “Policy summary,” for the purposes of this regulation;

(1) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information: current death benefit; annual contract premium; current cash surrender value; current dividend; application of current dividend; and amount of outstanding loan.

(2) For universal life policies, means a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

G. “Producer,” for the purpose of this regulation, shall be defined to include agents, brokers and producers.

H. “Replacing insurer” means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

I. “Registered contract” means a variable annuity contract or variable life; insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

J. “Replacement” means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) Reissued with any reduction in cash value; or

(5) Used in a financed purchase.

K. “Sales material” means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

Section 5. Duties of Producers

A. A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is “no,” the producer's duties with respect to replacement are complete.

B. If the applicant answered “yes” to the question regarding existing coverage referred to in Subsection A, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form which is not less favorable in any respect to the insured. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant.

C. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

D. In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

E. Except as provided in Section 7C, in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 6. Duties of Insurers that Use Producers

Each insurer shall:

A. Maintain a system of supervision and control to insure compliance with the requirements of this regulation that shall include at least the following:

(1) Inform its producers of the requirements of this regulation and :incorporate the requirements of this regulation into all relevant producer training manuals prepared by the insurer;

(2) Provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(3) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Paragraph (2) above;

(4) Procedures to confirm that the requirements of this regulation have been met; and

(5) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance with this regulation may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

B. Have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Insurance Department. The capacity to monitor shall include the ability to produce records for each producer's:

(1) Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(2) Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(3) Annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(4) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Subsection A(5) of this section; and

(5) Replacements, indexed by replacing producer and existing insurer;

C. Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

D. Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in Appendix A;

E. When the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material required by Section 5E, the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five (5) years after the termination or expiration of the proposed policy or contract;

F. Ascertain that the sales material and illustrations required by Section 5E of this regulation meet the requirements of this regulation and are complete and accurate for the proposed policy or contract;

G. If an application does not meet the requirements of this regulation, notify the producer and applicant and fulfill the outstanding requirements; and

H. Maintains records in paper, photograph, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Section 7. Duties of Replacing Insurers that Use Producers

A. Where a replacement is involved in the transaction, the replacing insurer shall:

(1) Verify that the required forms are received and are in compliance with this regulation;

(2) Notify any other existing insurer that may be affected by the proposed replacement within five (5) business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five (5) business days of a request from an existing insurer;

(3) Be able to produce copies of the notification regarding replacement required in Section 5B, indexed by producer, for at least five (5) years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(4) Provide to the policy or contract owner notice of the right to return the policy or contract within thirty (30) days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract; such notice may be included in Appendix A or C.

B. In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control allow credit for :he period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

C. If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to Section 5E, the insurer may:

(1) Require with each application a statement signed by the producer that:

(a) Represents that the producer used only company-approved sales material; and

(b) States that copies of all sales material were left with the applicant in accordance with Section 5D; and

(2) Within ten (10) days of the issuance of the policy or contract:

(a) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with Section 5D;

(b) Provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(c) Stress the importance of retaining copies of the sales material for future reference; and

(3) Be able to produce a copy of the letter or other verification in the policy file for at least five (5) years after the termination or expiration of the policy or contract.

Section 8. Duties of the Existing Insurer

Where a replacement is involved in the transaction, the existing insurer shall:

A. Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five (5) years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

B. Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within five (5) business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five (5) business days of receipt of the request from the policy or contract owner.

C. Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice, advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

Section 9. Duties of Insurers with Respect to Direct Response Solicitations

A. In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in Appendix B, or other substantially similar form which is no less favorable in any respect to the insured.

B. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) Provide to applicants or prospective applicants with the policy or contract a notice, as described in Appendix C, or other substantially similar form which is not less favorable in any respect to the insured. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this section; and

(2) Comply with the requirements of Section 7A(2), if the applicant furnishes the names of the existing insurers, and the requirements of Sections 7A(3), 7A(4) and 7B.

Section 10. Violations and Penalties

A. Any failure to comply with this regulation shall be considered a violation of Colorado Revised Statute 10-3-1104(1)(b). Examples of violations include:

(1) Any deceptive or misleading information set forth in sales material;

(2) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) The intentional incorrect recording of an answer;

(4) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

B. Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate this regulation.

C. Where it is determined that the requirements of this regulation have not been met the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in Appendix A or C.

D. Violations of this regulation shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred. In addition, where the commissioner has determined that the violations were material to the sale, the insurer may be required to make restitution and restore policy or contract values.

Section 11. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license.

Section 12. Severability

If any section or portion of a section of this regulation, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this regulation, or the applicability of its provisions to other persons, shall not be affected.

Section 13. Effective Date

This regulation shall be effective July 1,2001.

Section 14. History

Originally issued as Regulation 72-7, effective April 1,1972.

Regulation 72-7 repealed and replaced by Regulation 82-1, effective September 1,1982.

Renumbered as Regulation 4-1-4, effective June 1,1992.

Repealed and Repromulgated in full, effective July 1, 2001.

Appendix A Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___YES ___NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?___YES ___NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

Producer's Signature and Printed Name Date

I do not want this notice read aloud to me._____

(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable? Could they change? You're older-are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

Appendix B Notice Regarding Replacement

Replacing Your Life Insurance Policy or Annuity?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one-or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

Appendix C Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all o;7 the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ____YES ____NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?____YES ____NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should-make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable? Could they change? You're older-are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old

policy? How does the quality and financial stability of the new company compare with your existing company?

Regulation 4-1-5 Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables

I. Authority

This Regulation is promulgated under the authority of Sections 10-1-108(8), 10-1-109, and 10-7-305.1. (8) (f),. C.R.S.

II. Purpose

The purpose of this Regulation is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women to the extent necessary to comply with the U.S. Supreme Court decision in Arizona Governing Committee vs. Norris. No change in minimum valuation standards is implied by this rule.

The purpose of the January 1, 1989 amendment is to permit the use of smoker/nonsmoker status in providing the same cash surrender values and paid-up nonforfeiture benefits to both men and women.

III. Definitions

A. As used in this Regulation, "1980 CSO Table, with or without Ten-Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, referred to in section 10- 7-305.1 (8) C.R.S. and referred to as the Commissioners 1980, Standard Ordinary Mortality Table, with or without ten-year select mortality factors.

B. As used in this Regulation, "1980 CSO Table (M), with or without ten-year select mortality factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without ten-year select mortality factors.

C. As used in this Regulation, "1980 CSO Table (F), with or without ten-year select mortality factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without ten-year select mortality factors.

D. As used in this Regulation, "1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, referred to in section 10-7-305.1(8) (d) C.R.S. and referred to as; the Commissioners 1980 Extended Term Insurance Table.

E. As used in this Regulation, "1980 CET Table (M)" means that mortality table consisting of the rates, of mortality for male lives from the 1980 CET Table.

F. As used in this Regulation, "1980 BET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 BET Table.

G. As used in this Regulation, "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 BET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC, in December 1983.

IV. Rule

For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of section 10-7-305.1, C.R.S. for that policy form,

(i) a mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without ten- year select mortality factors may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(ii) a mortality table which is of the same blend as used in (i) but applied to form a blend of the 1980 BET Table (M) and the 1980 BET Table (F) may at the option of the company be substituted for the 1980 BET Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

The following tables will be considered as the basis for acceptable tables:

A. 100% Male 0% Female for tables to be designated as the “1980 CSO-A” and “1980 CET-A” tables.

B. 80% Male 20% Female for tables to be designated as the “1980 CSO-B” and “1980 CET-B” tables.

C. 60% Male 40% Female for tables to be designated as the “1980 CSO-C” and “1980 CET-C” tables.

D. 50% Male 50% Female for tables to be designated as the “1980 CSO-D” and “1980 CET-D” tables.

E. 40% Male 60% Female for tables to be designated as the “1980 CSO-E” and “1980 CET-E” tables.

F. 20% Male 80% Female for tables to be designated as the “1980 CSO-F” and “1980 CET-F” tables.

G. 0% Male 100% Female for tables to be designated as the “1980 CSO-G” and “1980 CET-G” tables.

Tables A and G are not to be used with respect to policies issued on or after January 1, 1985,-except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other or except for certain policies converted from group insurance. Such group conversions issued on or after January 1, 1986 must use Mortality Tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the Norris decision. This consideration has not been clearly defined by court or legislative action in all jurisdictions. The values of l000qx for blended Tables B, C, D, E and F are as published in the 1984 Proceedings of the National Association of Insurance Commissioners, Volume I, pages 396 - 400, and the method by which selection factors may be obtained is as described on page 457 of such publication. Table A is the same as 1980 CSO Table (M) and 1980 BET Table (M) and Table G is the same as 1980 CSO Table (F) and 1980 BET Table (F).

IV-A. Alternate Rule

In determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of section 10-7-305.1 C.R.S. for that policy form, in addition to the mortality tables that may be used according to Section IV,

(i) a mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without Ten-Year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

(ii) a mortality table which is of the same blend as used in (i) but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 BET Smoker Mortality Table or 1980 BET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 BET Table.

The following tables will be considered as the basis for acceptable Tables:

SA. 100% Male 0% Female smoker tables to be designated as the “1980 CSO-SA” and “1980 CET-SA” tables.

SB. 80% Male 20% Female smoker tables to be designated as the “1980 CSO-SB” and “1980 CET-SB” tables.

SC. 60% Male 40% Female smoker tables to be designated as the “1980 CSO-SC” and “1980 CET-SC” tables.

SD. 50% Male 50% Female smoker tables to be designated as the “1980 CSO-SD” and “1980 CET-SD” tables.

SE. 40% Male 60% Female smoker tables to be designated as the “1980 CSO-SE” and “1980 CET-SE” tables.

SF. 20% Male 80% Female smoker tables to be designated as the “1980 CSO-SF” and “1980 CET-SF” tables.

SG. 0% Male 100% Female smoker tables to be designated as the “1980 CSO-SG” and “1980 CET-SG” tables.

NA. 100% Male O% Female non-smoker tables to be designated as the “1980 CSO-NA” and “1980 CET-NA” tables.

NB. 80% Male 20% Female non-smoker tables to be designated as the “1980 CSO-NB” and “1980 CET-NB” tables.

NC. 60% Male 40% Female non-smoker tables to be designated as the “1980 CSO-NC” and “1980 CET-NC” tables.

ND. 50% Male 50% Female non-smoker tables to be designated as the “1980 CSO-ND” and “1980 CET-ND” tables.

NE. 40% Male 60% Female non-smoker tables to be designated as the “1980 CSO-NE” and “1980 CET-NE” tables.

ND. 20% Male 80% Female non-smoker tables to be designated as the “1980 CSO-NF” and “1980 CET-NF” tables.

NG. 0% Male 100% Female non-smoker tables to be designated as the “1980 CSO-NG” and “1980 CET-NG” tables.

Tables SA, SG, NA and NG are not acceptable as blended tables unless the proportion of persons insured is anticipated to be 90% or more of one sex or the other. The values of l000qx for blended Tables SB, SC, SD, SE, SF, NB, NC, ND, NE and NF are as published in the 1987 Proceedings of the National Association of Insurance Commissioners, Volume I, pages 521 - 530, and the method by which selection factors may be obtained is as described in the 1984 Proceedings of the National Association of Insurance Commissioners, Volume I, page 457. Tables SA and NA are the same as 1980 CSO Table (M) and 1980

BET Table (M) smoker and nonsmoker respectively, and Tables SG and NG are the same as 1980 CSO Table (F) and 1980 BET Table (F) smoker and nonsmoker respectively.

This rules does not include any later amendments to the NAIC tables described in sections IV and IV-A above.

Any person seeking information on the incorporated material set forth in Sections IV and IV-A above should contact the Chief Actuary at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202.

V. Unfair Discrimination

The tables described in Sections IV and IV-A above may be used to the extent necessary to comply with the requirements of the U.S. Supreme Court decision in Arizona Governing Committee vs. Norris. To that extent the use of the tables will not be a violation of section 10-3-1104, C.R.S.

VI. Separability

If any provision of this Regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

VII. Effective Date

The effective date of this Regulation is January 1, 1985.

The effective date of section IV-A is January 1, 1939; as corrected, effective December' 31, 1992.

Regulation 4-1-6 Permitting Smoker/Nonsmoker Mortality Tables for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits

I. Authority

This Regulation is promulgated under the authority of § § 10-1-109, 10-7-309, and 10-7-305.1, Colorado Revised Statutes (C.R.S.).

II. Purpose

The purpose of the regulation is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

III. Definitions

A. As used in this regulation, “1980 CSO Table, with or without; Ten-Year Select Mortality Factor” means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, referred to in § 10-7-305.1(8) C.R.S. and referred to as the Commissioners 1980 Standard Ordinary Mortality Table, with or without ten-year select mortality factors. The same factors will be used for both smokers and nonsmokers tables.

B. As used in this regulation, “1980 BET Table” means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance,

referred to in § 10-7-305.l(8)(d) and referred to as the Commissioners 1980 Extended Term Insurance Table.

C. As used in this regulation, "1958 CSO Table" means that mortality table developed by the Society of Actuaries Special Committee on new Mortality Tables, referred to in § 10-7-309(1)(a) and referred to as the Commissioners 1958 Standard Ordinary Mortality Table.

D. As used in this regulation, "1958 BET Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, referred to in § 10-7-305(4)(b) and referred to as the Commissioners 1958 Extended Term Insurance Table.

E. As used in this regulation, the phrase "smoker and nonsmoker mortality tables" refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in A through D of this section which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance Department staff as published in the 1984 Proceedings of the National Association of Insurance Commissioners, Volume I, pages 402 - 413.

F. As used in this regulation, the phrase "composite mortality tables" refers to the mortality tables defined in A through D of this section as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

(This rule does not include any later amendments to the NAIC tables described in (E) above. Any person seeking information on the incorporated material described above should contact the Chief Actuary at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202.)

IV. Alternate Tables

A. For any policy of insurance delivered or issued for delivery in this state after the operative date of § 10-7-305.1, C.R.S. for that : policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in section V of this regulation,

1. the 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without ten-year select mortality factors, and

2. the 1958 BET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 BET Table

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Provided that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 BET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

Provided further that the substitution of the 1958 CSO or 1958 GET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

B. For any policy of insurance delivered or issued for delivery in this state after the operative date of § 10-7-305.1, C.R.S. for that policy form, at the option of the company and subject to the conditions stated in section V of this regulation,

1. The 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without ten-year select mortality factors, may be substituted for the 1980 CSO Table, with or without ten-year select mortality factors, and

2. the 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

V. Conditions

For each plan of insurance with separate rates for smokers and nonsmokers an insurer may

1. use composite mortality tables to determine minimum reserve liabilities and minimum cash values and amounts of paid-up nonforfeiture benefits,

2. use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by § 10-7-303, C.R.S. and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or

3. use smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

VI. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

VII. Effective Date

The effective date of this regulation is January 1, 1985.

Amended Regulation 4-1-7 For Recognizing A New Annuity Mortality Table For Use In Determining Liabilities For Annuities

Section 1. Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to Section 10-1-108(8), 10-1-109, 10-7-309(2)(a)(I) and (2)(a)(m) Colorado Revised Statutes.

Section 2. Basis And Purpose

The purpose of this Regulation is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a," the 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.

Section 3. Definitions

A. As used in this Regulation" 1983 Table "a" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners. [See 1982 Proceedings of the NAIC II, page 454.]

B. As used in this Regulation "1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance [See 1984 Proceedings of the NAIC I, pages 414 to 415.]

C. As used in this rule "1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown at XLVII Transactions of the Society of Actuaries 866-867 (1995), and adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners. [See 1996 Proceedings of the NAIC, third quarter, pages 9,40, 908, 1202, 1236-1237.]

D. As used in this rule "Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown at XLVII Transactions of the Society of Actuaries 240 (1995) and adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners. [See 1996 Proceedings of the NAIC, third quarter, pages 9,40, 908,1202,1236-1237.]

(This rule does not include any later amendments to the NAIC and Society of Actuary tables described above. Any person seeking information should contact the Chief Actuary at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202).

Section 4. Rule

A. Individual Annuities Or Pure Endowment Contracts

1. Except as provided irr Subsections B and C of this section, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1981.

2. Except as provided in Subsection C of this section, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1985.

3. Except as provided in Subsection D of this section, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after March 2, 2001.

4. The 1983 Table “a” without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after March 2, 2001, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

   (a) Settlements of various forms of claims pertaining to court settlements or out of court settlements from ton actions;

   (b) Settlements involving similar actions such as workers' compensation claims; or

   (c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

B. Group Annuity Or Pure Endowment Contracts

1. Except as provided in Subsections B and C of this section, the 1983 GAM Table, the 1983 Table “a” and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for any annuity or pure endowment purchased on or after July l, 1981, under a group annuity or pure endowment contract.

2. Except as provided in Subsection C of this section, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January l, 1985 under a group annuity or pure endowment contract.

3. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after March 2, 2001 under a group annuity or pure endowment contract.

C. Application Of The 1994 GAR Table

In using the 1994 GAR Table, the mortality rate for a person age x in year (1994 + n) is calculated as follows:

$q_{x}^{1994+n} = q_{x}^{1994} (1 - AA_{x})^{n}$ where the q_{x}^{1994} and AA_{x} S are as specified in the 1994 GAR Table.

Section 5. Enforcement

Noncompliance with this regulation may result, after notice and hearing, in the imposition of any lawful sanction including the imposition of fines and suspension or revocation of license.

Section 6. Severability

If any provision of this Regulation or the application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected

Section 7. Effective Date

The effective date of this Regulation as amended is March 2, 2001.

Section 8. History

This regulation was originally effective January I, 1985.

Amended and Effective March 2, 2001.

Table 1 1994 Group Annuity Reserving Table

Age (x)	Male		Female		Age (x)	Male		Female	
	q_x	ΔA_x	q_x	ΔA_x		q_x	ΔA_x	q_x	ΔA_x
1	0.000592	0.020	0.000531	0.020	31	0.000821	0.005	0.000571	0.008
2	0.000400	0.020	0.000346	0.020	32	0.000839	0.005	0.000597	0.008
3	0.000332	0.020	0.000258	0.020	33	0.000848	0.005	0.000622	0.009
4	0.000259	0.020	0.000194	0.020	34	0.000849	0.005	0.000649	0.010
5	0.000237	0.020	0.000175	0.020	35	0.000851	0.005	0.000678	0.011
6	0.000227	0.020	0.000163	0.020	36	0.000862	0.005	0.000512	0.012
7	0.000217	0.020	0.000153	0.020	37	0.000891	0.005	0.000551	0.013
8	0.000201	0.020	0.000137	0.020	38	0.000939	0.006	0.000598	0.014
9	0.000194	0.020	0.000130	0.020	39	0.000999	0.007	0.000652	0.015
10	0.000197	0.020	0.000131	0.020	40	0.001072	0.008	0.000709	0.015
11	0.000208	0.020	0.000138	0.020	41	0.001156	0.009	0.000768	0.015
12	0.000226	0.020	0.000148	0.020	42	0.001252	0.010	0.000828	0.015
13	0.000255	0.020	0.000164	0.020	43	0.001352	0.011	0.000877	0.015
14	0.000297	0.019	0.000189	0.018	44	0.001458	0.012	0.000923	0.015
15	0.000345	0.019	0.000216	0.016	45	0.001578	0.013	0.000973	0.016
16	0.000391	0.019	0.000242	0.015	46	0.001722	0.014	0.001033	0.017
17	0.000430	0.019	0.000262	0.014	47	0.001899	0.015	0.001112	0.018
18	0.000460	0.019	0.000273	0.014	48	0.002102	0.016	0.001206	0.018
19	0.000484	0.019	0.000280	0.013	49	0.002326	0.017	0.001310	0.018
20	0.000507	0.019	0.000284	0.016	50	0.002579	0.018	0.001428	0.017
21	0.000530	0.018	0.000286	0.017	51	0.002872	0.019	0.001568	0.016
22	0.000556	0.017	0.000289	0.017	52	0.003213	0.020	0.001734	0.014
23	0.000589	0.015	0.000292	0.016	53	0.003584	0.020	0.001907	0.012
24	0.000624	0.013	0.000291	0.015	54	0.003979	0.020	0.002084	0.010
25	0.000661	0.010	0.000291	0.014	55	0.004420	0.019	0.002294	0.008
26	0.000696	0.006	0.000294	0.012	56	0.004949	0.018	0.002563	0.006
27	0.000727	0.005	0.000302	0.012	57	0.005581	0.017	0.002919	0.005
28	0.000754	0.005	0.000315	0.012	58	0.006300	0.016	0.003359	0.005
29	0.000779	0.005	0.000331	0.012	59	0.007090	0.016	0.003863	0.005
30	0.000801	0.005	0.000351	0.010	60	0.007976	0.016	0.004439	0.005

Table 1 1994 Group Annuity Reserving Table (continued)

Age (x)	Male		Female		Age (x)	Male		Female	
	q_x	ΔA_x	q_x	ΔA_x		q_x	ΔA_x	q_x	ΔA_x
61	0.008986	0.015	0.005093	0.005	91	0.167260	0.004	0.128751	0.003
62	0.010147	0.015	0.005832	0.005	92	0.182281	0.003	0.141975	0.003
63	0.011471	0.014	0.006677	0.005	93	0.198392	0.003	0.155931	0.002
64	0.012940	0.014	0.007621	0.005	94	0.215700	0.003	0.170677	0.002
65	0.014535	0.014	0.008626	0.005	95	0.233606	0.002	0.186213	0.002
66	0.016239	0.013	0.009694	0.005	96	0.251510	0.002	0.202558	0.002
67	0.018034	0.013	0.010764	0.005	97	0.268815	0.002	0.219653	0.001
68	0.019859	0.014	0.011763	0.005	98	0.285277	0.001	0.237713	0.001
69	0.021729	0.014	0.012709	0.005	99	0.301298	0.001	0.256712	0.001
70	0.023750	0.015	0.013720	0.005	100	0.317238	0.001	0.276427	0.001
71	0.025951	0.015	0.014953	0.006	101	0.333461	0.000	0.296629	0.000
72	0.028481	0.015	0.016506	0.006	102	0.350339	0.000	0.317093	0.000
73	0.031201	0.015	0.018344	0.007	103	0.368542	0.000	0.338505	0.000
74	0.034051	0.015	0.020381	0.007	104	0.387855	0.000	0.361016	0.000
75	0.037211	0.014	0.022686	0.008	105	0.407224	0.000	0.385597	0.000
76	0.040858	0.014	0.025325	0.008	106	0.425599	0.000	0.405217	0.000
77	0.045171	0.013	0.028366	0.007	107	0.441935	0.000	0.424846	0.000
78	0.050211	0.012	0.031727	0.007	108	0.457553	0.000	0.444368	0.000
79	0.055861	0.011	0.035362	0.007	109	0.473150	0.000	0.464649	0.000
80	0.062027	0.010	0.039396	0.007	110	0.486745	0.000	0.482325	0.000
81	0.068615	0.009	0.043952	0.007	111	0.496256	0.000	0.495110	0.000
82	0.075532	0.008	0.049153	0.007	112	0.500000	0.000	0.500000	0.000
83	0.082510	0.008	0.054857	0.007	113	0.500000	0.000	0.500000	0.000
84	0.089613	0.007	0.060979	0.007	114	0.500000	0.000	0.500000	0.000
85	0.097240	0.007	0.067738	0.006	115	0.500000	0.000	0.500000	0.000
86	0.105792	0.007	0.075347	0.005	116	0.500000	0.000	0.500000	0.000
87	0.115671	0.006	0.084023	0.004	117	0.500000	0.000	0.500000	0.000
88	0.126980	0.005	0.093820	0.004	118	0.500000	0.000	0.500000	0.000
89	0.139452	0.005	0.104594	0.003	119	0.500000	0.000	0.500000	0.000
90	0.152931	0.004	0.116265	0.003	120	1.000000	0.000	1.000000	0.000

Table 2 Annuity 2000 Mortality Table

Age Nearest Birthday (x)	$1000q_x$		Age Nearest Birthday (x)	$1000q_x$		Age Nearest Birthday (x)	$l_{60}l_x$	
	Male	Female*		Male	Female*		Male	Female*
5	0.291	0.171	43	1.362	0.781			
6	0.270	0.141	44	1.547	0.855	81	59.643	35.993
7	0.257	0.118	45	1.753	0.939	82	55.851	40.852
8	0.294	0.118	46	1.974	1.035	83	61.080	45.690
9	0.225	0.121	47	2.211	1.141	84	66.948	51.456
10	0.350	0.128	48	2.460	1.261	85	73.275	57.913
11	0.271	0.133	49	2.721	1.393	86	80.076	65.119
12	0.388	0.142	50	2.994	1.538	87	87.370	73.126
13	0.402	0.152	51	3.279	1.695	88	95.169	81.991
14	0.414	0.164	52	3.576	1.864	89	103.455	91.577
15	0.425	0.177	53	3.884	2.047	90	112.208	101.728
16	0.437	0.190	54	4.203	2.244	91	121.402	112.395
17	0.449	0.204	55	4.534	2.257	92	131.017	123.549
18	0.463	0.219	56	4.876	2.589	93	141.030	134.486
19	0.480	0.234	57	5.228	2.942	94	151.432	145.589
20	0.499	0.250	58	5.593	3.218	95	162.179	156.846
21	0.519	0.265	59	5.988	3.532	96	173.279	167.841
22	0.542	0.281	60	6.428	3.883	97	184.706	178.563
23	0.566	0.298	61	6.933	4.262	98	196.946	189.604
24	0.592	0.314	62	7.520	4.668	99	210.454	201.557
25	0.616	0.331	63	8.207	5.144	100	225.806	215.013
26	0.639	0.347	64	9.008	5.671	101	243.398	230.565
27	0.659	0.362	65	9.940	6.250	102	263.745	248.805
28	0.675	0.376	66	11.016	6.878	103	287.334	270.326
29	0.687	0.389	67	12.251	7.555	104	314.649	295.719
30	0.694	0.402	68	13.657	8.287	105	346.177	325.576
31	0.699	0.414	69	15.233	9.105	106	382.403	360.491
32	0.700	0.425	70	16.979	10.034	107	423.813	401.054
33	0.701	0.436	71	18.891	11.117	108	470.893	447.860
34	0.702	0.449	72	20.967	12.386	109	524.128	501.498
35	0.704	0.463	73	23.209	13.871	110	584.004	562.563
36	0.719	0.481	74	25.644	15.592	111	631.007	631.645
37	0.749	0.504	75	28.304	17.564	112	725.612	708.238
38	0.796	0.532	76	31.220	19.805	113	808.336	796.233
39	0.864	0.567	77	34.425	22.328	114	899.633	895.822
40	0.953	0.609	78	37.948	25.158	115	1000.000	1000.000
41	1.065	0.658	79	41.812	28.341	* Based on 50% of Female Improvement Scale G.		
42	1.201	0.715	80	46.037	31.933			

Table 3 1983 Table a

Age Nearest Birthday (x)	1000q_x		Age Nearest Birthday (x)	1000q_x		Age Nearest Birthday (x)	1000q_x	
	Male	Female		Male	Female		Male	Female
5	0.377	0.194	42	1.673	0.867	78	51.756	32.328
6	0.350	0.160	43	1.886	0.942	80	57.026	36.398
7	0.333	0.134	44	2.129	1.026	81	62.791	40.975
8	0.352	0.124	45	2.399	1.122	82	69.081	46.121
9	0.368	0.136	46	2.693	1.231	83	75.908	51.889
10	0.382	0.141	47	3.009	1.356	84	83.270	58.336
11	0.394	0.147	48	3.343	1.499	85	90.987	65.518
12	0.405	0.155	49	3.694	1.657	86	99.122	73.492
13	0.415	0.163	50	4.057	1.830	87	107.877	82.318
14	0.425	0.173	51	4.433	2.016	88	116.316	92.017
15	0.435	0.184	52	4.812	2.215	89	125.394	102.491
16	0.446	0.201	53	5.198	2.426	90	134.887	113.601
17	0.458	0.214	54	5.591	2.650	91	144.873	126.257
18	0.472	0.229	55	5.994	2.891	92	155.429	137.322
19	0.488	0.244	56	6.409	3.151	93	166.629	149.462
20	0.505	0.260	57	6.839	3.432	94	178.537	161.834
21	0.521	0.276	58	7.290	3.739	95	191.214	174.258
22	0.546	0.293	59	7.782	4.081	96	204.721	186.535
23	0.579	0.311	60	8.338	4.467	97	219.120	198.646
24	0.596	0.330	61	8.983	4.904	98	234.735	211.162
25	0.622	0.349	62	9.740	5.413	99	251.889	224.445
26	0.650	0.368	63	10.620	5.990	100	270.906	239.316
27	0.677	0.387	64	11.664	6.633	101	292.111	255.953
28	0.704	0.405	65	12.851	7.336	102	315.826	275.201
29	0.731	0.423	66	14.199	8.090	103	342.377	297.190
30	0.759	0.441	67	15.717	8.888	104	372.086	323.290
31	0.786	0.460	68	17.414	9.731	105	405.278	353.414
32	0.814	0.479	69	19.296	10.623	106	442.277	388.111
33	0.843	0.499	70	21.371	11.597	107	483.406	428.023
34	0.876	0.521	71	23.647	12.905	108	528.989	473.692
35	0.917	0.548	72	26.131	14.319	109	579.351	525.658
36	0.968	0.574	73	28.833	15.986	110	634.814	584.462
37	1.032	0.607	74	31.794	17.909	111	695.704	650.646
38	1.114	0.646	75	35.046	20.127	112	762.343	724.750
39	1.216	0.69	76	38.631	22.654	113	835.056	807.316
40	1.341	0.742	77	42.587	25.509	114	914.167	898.885
41	1.492	0.801	78	46.951	28.717	115	1000.000	1000.000

Table 4 1983 Group Annuity Mortality Table

Age	q_x		Age	q_x		Age	q_x	
	Male	Female		Male	Female		Male	Female
5	0.000342	0.000171	41	0.001370	0.000716	76	0.049388	0.027185
6	0.000318	0.000140	42	0.001527	0.000775	77	0.054758	0.030072
7	0.000302	0.000118	43	0.001715	0.000842	78	0.060678	0.034659
8	0.000294	0.000104	44	0.001932	0.000919	79	0.067128	0.038249
9	0.000292	0.000097	45	0.002183	0.001010	80	0.074070	0.042945
10	0.000293	0.000096	46	0.002471	0.001117	81	0.081484	0.047955
11	0.000298	0.000104	47	0.002790	0.001237	82	0.089320	0.053691
12	0.000304	0.000112	48	0.003138	0.001366	83	0.097522	0.059671
13	0.000310	0.000122	49	0.003513	0.001505	84	0.106047	0.065857
14	0.000317	0.000131	50	0.003909	0.001647	85	0.114836	0.069918
15	0.000325	0.000140	51	0.004324	0.001793	86	0.124170	0.076570
16	0.000333	0.000149	52	0.004755	0.001949	87	0.133870	0.083470
17	0.000343	0.000159	53	0.005200	0.002120	88	0.144077	0.091935
18	0.000353	0.000168	54	0.005660	0.002313	89	0.154859	0.101354
19	0.000365	0.000179	55	0.006131	0.002541	90	0.166307	0.111750
20	0.000377	0.000189	56	0.006618	0.002803	91	0.178214	0.123078
21	0.000392	0.000201	57	0.007139	0.003103	92	0.190460	0.135930
22	0.000408	0.000212	58	0.007719	0.003443	93	0.203007	0.149577
23	0.000424	0.000225	59	0.008384	0.003821	94	0.215994	0.165103
24	0.000443	0.000239	60	0.009158	0.004241	95	0.234086	0.183419
25	0.000464	0.000253	61	0.010064	0.004703	96	0.248436	0.201757
26	0.000488	0.000268	62	0.011133	0.005210	97	0.263954	0.222944
27	0.000513	0.000284	63	0.012391	0.005769	98	0.280803	0.243899
28	0.000542	0.000302	64	0.013868	0.006386	99	0.299154	0.268183
29	0.000572	0.000320	65	0.015592	0.007066	100	0.319185	0.295187
30	0.000607	0.000342	66	0.017579	0.007817	101	0.341086	0.325229
31	0.000645	0.000364	67	0.019804	0.008681	102	0.365052	0.358897
32	0.000687	0.000388	68	0.022329	0.009705	103	0.391102	0.396843
33	0.000734	0.000414	69	0.025217	0.010925	104	0.427252	0.438560
34	0.000785	0.000443	70	0.028530	0.012385	105	0.469531	0.487816
35	0.000860	0.000476	71	0.032354	0.014128	106	0.521965	0.545886
36	0.000907	0.000503	72	0.036776	0.016160	107	0.586518	0.614209
37	0.000966	0.000536	73	0.036880	0.018481	108	0.665268	0.694885
38	0.001039	0.000572	74	0.040388	0.021092	109	0.760215	0.789474
39	0.001128	0.000617	75	0.044597	0.023993	110	1.000000	1.000000
40	0.001238	0.000668						

Amended Regulation 4-1-8 Concerning The Disclosure Requirements For Life Insurance Illustrations

Section 1. Authority

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Section 15. History

Section 1. Authority

This regulation is issued based upon the authority granted the commissioner under Section 10-1- 109, C.R.S. and 10-3-1110(1), C.R.S.

Section 2. Purpose

The purpose of this regulation is to provide roles for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms, used in the illustration, in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

Section 3. Scope

This regulation applies to all group and individual life insurance policies and certificates except:

A. Variable life insurance;

B. Individual and group annuity contracts;

C. Credit life insurance; or

D. Life insurance policies whose death benefits on any individual will not exceed $10,000 during the term of the policy.

Section 4. Definitions

For the purposes of this regulation:

A. “Actuarial Standards Board” means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

B. “Contract premium” means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

C. “Currently payable scale” means a scale of non-guaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next ninety-five (95) days.

D. “Disciplined current scale” means a scale of non-guaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. The disciplined current scale standards established by the Actuarial Standards Board should be consulted in the preparation of illustrations only to the extent these standards:

(1) Are consistent with all provisions of this regulation;

(2) Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;

(3) Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and

(4) Do not permit assumed expenses to be less than minimum assumed expenses.

E. “Generic name” means a short title descriptive of the policy being illustrated such as “whole life,” “term life” or “flexible premium adjustable life.”

F. “Guaranteed elements” and “non-guaranteed elements” .

(1) “Guaranteed elements” means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.

(2) “Non-guaranteed elements” means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

G. “Illustrated scale” means a scale of non-guaranteed elements currently being illustrated that is not more favorable to the policy owner than the lesser of:

(1) The disciplined current scale; or

(2) The currently payable scale.

H. “Illustration” means a presentation or depiction mat includes non-guaranteed elements of a policy of life insurance over a period of years and that is one of the three (3) types defined below:

(1) “Basic illustration” means a ledger or proposal used in the sale of a life insurance policy mat shows both guaranteed and non-guaranteed elements.

(2) “Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this regulation, and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

(3) “In force illustration” means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

I. “Illustration actuary” means an actuary meeting the requirements of Section 11 C of this regulation who certifies to illustrations.

J. “Lapse-supported illustration” means an illustration of a policy form failing the test of self-supporting as defined in this regulation, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five (5) years and 100 percent policy persistency thereafter.

K.

(1) “Minimum assumed expenses” means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms

from the following:

(a) Fully allocated expenses;

(b) Marginal expenses; and

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies.

(2) Marginal expenses may be used only if greater than a generally recognized expense table. If a generally recognized expense table is not used, fully allocated expenses must be used.

L. "Non-term group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

(1) Every plan of coverage was selected by the employer or other group representative;

(2) Some portion of the premium is paid by the group or through payroll deduction; and

(3) Group underwriting or simplified underwriting is used.

M. "Policy owner" means the owner named in the policy or the certificate holder in the case of a group policy.

N. "Premium outlay" means the amount of premium assumed to be paid by the policy owner or other premium payer out-of-pocket

O. "Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policy owner value available. For this purpose, policy owner value will include cash surrender values and any other illustrated benefit amounts available at the policy owner's election.

Section 5. Policies To Be Illustrated

A. Each insurer marketing policies to which this regulation is applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For all policy forms being actively marketed on the effective date of this regulation, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after the effective date of this regulation, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

B. If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited. Insureds who purchased a policy without an illustration may subsequently request an in-force illustration for that policy.

C. If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with this regulation is required, except that a basic illustration need not be provided to individual numbers of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration furnished an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration

representative of the coverage on the lives of members of the group or the multiple lives covered.

D. Potential enrollees of non-term group life subject to this regulation shall be furnished a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of this regulation, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life who enroll for more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any non-term group life enrollee who requests it

Section 6. General Roles And Prohibitions

A. An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of this regulation, be clearly labeled “life insurance illustration” and contain the following basic information:

(1) Name of insurer,

(2) Name and business address of producer or insurer's authorized representative, if any;

(3) Name, age and sex of proposed insured, except where a composite illustration is permitted under this regulation;

(4) Underwriting or rating classification upon which the illustration is based;

(5) Generic name of policy, the company product name, if different, and form number;

(6) Initial death benefit; and

(7) Dividend option election or application of non-guaranteed elements, if applicable.

B. When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

(1) Represent the policy as anything other than a life insurance policy,

(2) Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(3) State or imply that the payment or amount of non-guaranteed elements is guaranteed;

(4) Use an illustration that does not comply with the requirement:; of this regulation;

(5) Use an illustration that at any policy duration depicts policy performance more favorable to the policy owner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

(6) Provide an applicant with an incomplete illustration;

(7) Represent in any way that premium payments will not be .required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

(8) Use the term “vanish” or “vanishing premium,” or a similar term that implies the policy becomes paid up to describe a plan for using non-guaranteed elements to pay a portion

of future premiums;

(9) Except for policies that can never develop nonforfeiture values , use an illustration that is "lapse-supported" ; or

(10) Use an illustration that is not "self-supporting."

C. If an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.

Section 7. Standards For Basic Illustrations

A. Format A basic illustration shall conform with the following requirement;:

(1) The illustration shall be labeled with the date on which it was prepared.

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7."

(3) The assumed dates of payment receipt and benefit pay-out within a policy year shall be clearly identified.

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

(5) The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

(6) Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

(7) If the illustration shows any non-guaranteed elements, they cannot be based on a scale more favorable to the policy owner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled non-guaranteed.

(8) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page one for guaranteed elements.")

(9) The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

(10) The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policy owner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

(11) Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

(12) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed

(b) The assumptions on which they are based are subject to change by the insurer, and

(c) Actual results may be more or less favorable.

(13) If the illustration shows that the premium payer may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

(14) If the applicant informs the producer that he/she plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration stall reflect those plans and the impact on future policy benefits and values.

B. Narrative Summary. A basic illustration shall include the following:

(1) A brief description of the policy being illustrated, including a statement that it is a life insurance policy,

(2) A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

(3) A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy,

(4) Identification and a brief definition of column headings and key terms used in the illustration; and

(5) A statement containing in substance the following: “This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown.”

C. Numeric Summary.

(1) Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years five (5), ten (10) and twenty (20) and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary shall show policy years five (5), ten (10), twenty (20) and thirty (30).

The numeric summary bases are:

(a) Policy guarantees;

(b) Insurer's illustrated scale;

(c) Insurer's illustrated scale used but with the non-guaranteed elements reduced as follows:

(i) Dividends at fifty percent (50%) of the dividends contained in the illustrated scale used;

(ii) Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

(iii) All non-guaranteed charges, including but not limited to, term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

(2) In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three (3) bases in Subsection (c)(1), above.

D. Statements. Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policy owner in the case of an illustration provided at time of delivery, as required in this regulation.

(1) A statement to be signed and dated by the applicant or policy owner reading as follows: “I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed.”

(2) A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows: “I certify that this illustration has been presented to the applicant and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration.”

E. Tabular Detail.

(1) A basic illustration shall include the following for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(a) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(b) The corresponding guaranteed death benefit, as provided in the policy, and

(c) The corresponding guaranteed value available upon surrender, as provided in the policy.

(2) For a policy mat provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

(3) Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a non-guaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

Section 8. Standards For Supplemental Illustrations

A. A supplemental illustration may be provided so long as:

(1) It is appended to, accompanied by or preceded by a basic illustration that complies with this regulation;

(2) The non-guaranteed elements shown are not more favorable to the policy owner than the corresponding elements based on the scale used in the basic illustration;

(3) It contains the same statement required of a basic illustration that non- guaranteed elements are not guaranteed; and

(4) For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

B. The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

Section 9. Delivery Of Illustration And Record Retention

A.

(1) If a basic illustration is used by an insurance producer or other authorized representative of the insurer m the sale of a life insurance policy, and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with this regulation, shall be submitted to the insurer at the time of policy application, A copy also shall be provided to the applicant

(2) If the policy is issued other man as applied for, a revised basic illustration conforming to the policy, as issued, shall be sent with the policy. The revised illustration shall conform to the requirements of this regulation* shall be labeled “Revised Illustration” and shall be signed and dated by the applicant or policy owner and producer, or other authorized representative of the insurer, no later than the time the policy is delivered. A copy shall be provided to the insurer and the policy owner.

B.

(1) If no illustration is used by an insurance producer, or other authorized representative in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form, the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding

that an illustration conforming to the policy as issued, will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

(2) If the policy is issued, a basic illustration conforming to the: policy as issued shall be sent with the policy and signed and dated by the applicant or policy owner and producer or other authorized representative of the insurer no later than the time the policy is delivered A copy shall be provided to the insurer and the policy owner.

C. If the basic illustration or revised illustration is sent to the applicant or policy owner by mail, from the insurer, it shall include instructions for the applicant or policy owner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subsection shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

D. A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification that either no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three (3) years after the policy is no longer in force. A copy need not be retained if no policy is issued.

Section 10. Annual Report: Notice To Policy Owners

A. In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policy owner with an annual report on the status of the policy that shall contain at least the following information:

(1) For universal life policies, the report shall include the following:

(a) The beginning and end date of the current report period;

(b) The policy value at the end of the previous report period and at the end of the current report period;

(c) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(d) The current death benefit at the end of the current report period on each life covered by the policy;

(e) The net cash surrender value of the policy as of the end of the current report period;

(f) The amount of outstanding loans, if any, as of the end of the current report period; and

(g) For fixed premium policies:

If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(h) For flexible premium policies:

If assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report

(2) For all other policies, where applicable:

(a) Current death benefit;

(b) Annual contract premium;

(c) Current cash surrender value;

(d) Current dividend;

(e) Application of current dividend; and

(f) Amount of outstanding loan.

(3) Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer."

B. If the annual report does not include an in force illustration, it shall contain the following notice displayed prominently: "IMPORTANT POLICY OWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's phone number], writing to [insurer's name] at [insurer's address] or contacting your agent If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department" The insurer may vary the sequential order of the methods for obtaining an in force illustration.

C. Upon the request of the policy owner, the insurer shall furnish an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of Sections 6A, 6B, 7A and 7E of this regulation. No signature or other acknowledgment of receipt of this illustration shall be required.

D. If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

Section 11. Annual Certifications

All annual reports, certifications, and appointments required by this section shall be delivered to the attention of the: Rates and Forms Section, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202.

A. The board of directors of each insurer shall appoint one or more illustration actuaries.

B. The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Regulation on Life Insurance Illustrations, promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of this regulation.

C. The illustration actuary shall:

(1) Be a member in good standing of the American Academy of Actuaries;

(2) Be familiar with the standard of practice regarding life insurance policy illustrations;

(3) Not have been found by the commissioner, following appropriate notice and hearing, to have:

(a) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of his or her dealings as an illustration actuary;

(b) Been found guilty of fraudulent or dishonest practices;

(c) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(d) Resigned or been removed as an illustration actuary within the past five (5) years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards.

(4) Notify the commissioner of any action taken by a commissioner of another state similar to that under Paragraph (3) above;

(5) Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five (5) years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification; and

(6) Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(a) Fully allocated expenses;

(b) Marginal expenses; or

(c) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies.

D. The illustration actuary shall file a certification with the board and with the commissioner

(1) Annually for all policy forms for which illustrations are used; and

(2) Before a new policy form is illustrated.

(3) If an error in a previous certification is discovered, the illustration a actuary shall notify the board of directors of the insurer and the commissioner promptly.

E. If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly of his or her inability to certify.

F. A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

(1) That the illustration formats meet the requirements of this regulation and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

(2) That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in Subsection C(6) of this section.

G. The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

H. If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change.

Section 12. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 13. Severability

If any section or portion of a section of this regulation, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulation, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Section 14. Effective Date

This regulation shall become effective November 1, 2000.

Section 15. History

Originally issued as Regulation 4-1-8, effective April 1, 1997. Amended Regulation effective November 1, 2000.

New Regulation 4-1-9 Valuation of Life Insurance Policies Model Regulation

(Including the Introduction and Use of New Select Mortality Factors)

Section 1. Authority

This regulation is issued under the authority of § § 10-1-109 and 10-7-313.7, C.R.S..

Section 2. Purpose

The purpose of this regulation is to clarify the provisions of the Standard Nonforfeiture and Valuation Act (Part 3 of Article 7, C.R.S.) by providing:

A. Tables of select mortality factors and rules for their use:

B. Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

C. Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

The method for calculating basic reserves defined in this regulation will constitute the Commissioners' Reserve Valuation Method for policies to which this regulation is applicable.

Section 3. Applicability

This regulation shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this regulation, subject to the following exceptions and conditions.

A. Exceptions

1. This regulation shall not apply to any individual life insurance policy issued on or after the effective date of this regulation if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this regulation, that

guarantees the premium rates of the new policy. This regulation also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

2. This regulation shall not apply to any universal life policy that meets all of the following requirements:

   a. The secondary guarantee period, if any, is five (5) years or less;

   b. The specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in Section 4F and the applicable valuation interest rate; and

   c. The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

3. This regulation shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

4. This regulation shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

5. This regulation shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Conditions

1. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of Section 6.

2. Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of Section 7.

Section 4. Definitions

For purposes of this regulation:

A. “Basic reserves” means reserves calculated in accordance with the principles of § 10-7-310, C.R.S.

B. “Contract segmentation method” means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in Subsection F of this Section, (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in Section 5B of this regulation.

The length of a particular contract segment shall be set equal to the minimum of the value t for which Gt is greater than R_t (if G_t never exceeds R_t, the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

G_t = 702_4_20060430_4-1-9inline1.jpg

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, t is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ =Guaranteed gross premium per thousand of face amount for year t of the segment, ignoring policy fees only if level for the premium paying period of the policy.

R_t = 702_4_20060430_4-1-9inline2.jpg , However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and $q_{x-k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of Section 5B(2) if Section 5B(3) is elected for deficiency reserves.

However, if GP_{x+k-t} is greater than 0 and $GP_{x+k-t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k-t} and $GP_{x-k-t-1}$ are both equal to 0, G_t shall be deemed to be 0

C. “Deficiency reserves” means the excess, if greater than zero, of

1. Minimum reserves calculated in accordance with the principles of § 10-7-313, C.R.S. over

2. Basic reserves.

D. “Guaranteed gross premiums” means the premiums under a policy of life insurance that are guaranteed and determined at issue.

E. “Maximum valuation interest rates” means the interest rates defined in § 10-7-309.5, C.R.S. (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

F. “1980 CSO valuation tables” means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments; to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

G. “Scheduled gross premium” means the smallest illustrated gross premium at issue for Other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in Section 7A(3), if any, or else the minimum premium described in Section 7A(4).

H.

1. “Segmented reserves” means reserves, calculated using segments produced by “the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

    a. The present value of the death benefits within the segment, plus

    b. The present value of any unusual guaranteed cash value (see Section 6D) occurring at the end of the segment, less

    c. Any unusual guaranteed cash value occurring at the start of the segment plus

    d. For the first segment only, the excess of the item (i) over item (ii), as follows:

        i. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

        ii. A net one year term premium for the benefits provided for in the first policy year.

2. The length of each segment is determined by the “contract segmentation method,” as defined in this Section.

3. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

4. For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

I. “Tabular cost of insurance” means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

J. “Ten-year select factors” means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

K. 1. “Unitary reserves” means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

    a. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

b. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Item (i) over Item (ii), as follows:

i. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

ii. A net one year term premium for the benefits provided for in the first policy year.

2. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

L. "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

Section 5. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves

A. At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for this purpose). If select mortality factors are elected, they may be:

1. The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. The select mortality factors in the Appendix; or

3. Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating basic reserves.

B. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner). If select mortality factors are elected, they may be:

1. The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC

Standard Valuation Law;

2. The select mortality factors in the Appendix of this regulation;

3. For durations in the first segment, X percent of the select mortality factors in the Appendix, subject to the following:

    a. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

    b. X shall not be less than twenty percent (20%);

    c. X shall not decrease in any successive policy years;

    d. X is such that, when using the valuation interest rate used for basic reserves, Item (i) is greater than or equal to Item (ii);

        i. The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

        ii. The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

    e. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

    f. The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Section 5, Subsection B(3);

    g. The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of Section 5, Subsection B(3); and

    h. The appointed actuary shall specifically take into account the adverse effect on expected morality and lapsation of any anticipated or actual increase in gross premiums

    i. If X is less than 100 percent at any duration for any policy, the following requirements shall be met

        i. The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Colorado Insurance Regulation 3-1-8; and

        ii. The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of Section 5, Subsection B(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging

experience.

4. Any other table of select mortality factors adopted by the NAIC after the effective date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating deficiency reserves.

C. This Subsection C applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment However, if the first segment is less than ten (10) years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

D. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

E. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

F. The commissioner may require that the company document the extent of the adequacy of reserve for specified blocks, including but-not limited to, policies issued prior to the effective date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Colorado Insurance Regulation 3-1-8.

Section 6. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)

A. Basic Reserves

Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in Paragraph (1) or (2) below may be made:

1. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

2. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

B. Deficiency Reserves

1. The deficiency reserve at any duration shall be calculated:

a. On a unitary basis if the corresponding basic reserve determined by Section 6, Subsection A is unitary;

b. On a segmented basis if the corresponding basic reserve determined by Section 6, Subsection A is segmented; or

c. On the segmented basis if the corresponding basic reserve determined by Section 6, Subsection A is equal to both the segmented reserve and the unitary reserve.

2. This Subsection 2 shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in Section 5B) and rate of interest.

3. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Section 5B.

4. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

C. Minimum Value

Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid- terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

D. Unusual Pattern of Guaranteed Cash Surrender Values

1. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less then the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

2. The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an n year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

a. n is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

i. The date of the next unusual guaranteed cash surrender value, if any, that is

scheduled after the valuation date; or

ii. The mandatory expiration date of the policy; and

b. The net premium for a given year during the n year period is equal to the pro duct of the net to gross ratio and the respective gross premium; and

c. The net to gross ratio is equal to item (i) divided by item (ii) as follows:

i. The present value, at the beginning of the nyear period, of death benefits payable during the n year period plus the present value, at the beginning of the n year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the n year period.

ii. The present value, at the beginning of the n year period, of the scheduled gross premiums payable during the n year period.

3. For purposes of this Subsection 3, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

a. One hundred ten percent (110%) of the scheduled gross premium for that year,

b. One hundred ten percent (110%) of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

c. Five percent (5%) of the first policy year surrender charge, if any.

E. Optional Exemption for Yearly Renewable Term Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection C.

3. Deficiency reserves.

a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above.

4. For purposes of this Subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

5. A reinsurance agreement shall be considered YRT reinsurance for purposes of this Subsection

if only the mortality risk is reinsured.

6. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

F. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies. At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

1. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

2. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 6C. I

3. Deficiency reserves.

   a. For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

   b. Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (a) above

4. For purposes of this Subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any o :her table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

5. A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this Subsection if:

   a. The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

   b. The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

6. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this Subsection may be used after the initial period if:

   a. The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

   b. The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

   c. After the initial period of coverage, the policy meets the conditions of Paragraph (5) above.

7. If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this regulation.

G. Exemption from Unitary Reserves for Certain n-Year Renewable Term Life Insurance Policies.

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

1. The policy consists of a series of n-year periods, including the first period and all renewal periods, where n is the same for each period, except that for the final renewal period, nmay be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

2. The guaranteed gross premiums in all n-year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

3. There are no cash surrender values in any policy year.

H. Exemption from Unitary Reserves for Certain Juvenile Policies

Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

1. At issue, the insured is age twenty-four (24) or younger;

2. Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and

3. After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

Section 7. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period

A. General

1. Policies with a secondary guarantee include:

   a. A policy with a guarantee that the policy will remain in force at the original schedule of benefits subject only to the payment of specified premiums;

   b. A policy in which the minimum premium at any duration is less man the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose; or

   c. A policy with any combination of subparagraph (a) and (b), above.

2 A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date, of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subsections B and C below shall be recalculated from issue to reflect these changes.

3. Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

4. For purposes of this Section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest auditing rate, which are all guaranteed at issue.

5. The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Section 5B(2), (3), and (4) may not be used to calculate the one-year valuation premiums.

6. The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

B. Basic Reserves for the Secondary Guarantees

Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in Section 4B.

C. Deficiency Reserves for the Secondary Guarantees

Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in Section 6B with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

D. Minimum Reserves

The minimum reserves during the secondary guarantee period are the greater of:

1. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees: or

2. The minimum reserves required by other rules or regulations governing universal life plans.

Section 8. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of Cease & Desist Orders, and /or other suspensions or revocations of license.

Section 9. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 10. Effective Date

This regulation shall become effective January 1, 2000.

Section 11. History

New regulation, effective January 1, 2000.

Appendix Select Mortality Factors

This appendix contains tables of select mortality factors that are the bases to which the respective percentage of Section 5A(2), 5B(2) and 5B(3) are applied.

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male nonsmoker, (3) male smoker, (4) female aggregate, (5) female nonsmoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables. For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table in this Appendix, plus twenty percent (20%) of the appropriate female table in this Appendix.

Appendix

SELECT MORTALITY FACTORS

Male, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	76	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	66	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100

Male, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	66	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100

Male, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
51	27	35	40	43	45	47	48	50	51	53	57	60	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	48	50	55	57	58	59	100	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	53	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male, Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	99	99	99	100	99	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	83	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	73	75	76	78	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	71	73	76	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	86	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100

Male, Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	66	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	56	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	58	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	76	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	76	76	76	82	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	71	77	77	83	88	94	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	79	79	84	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	80	85	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	68	70	69	70	73	73	78	84	89	95	100
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100

Female, Aggregate

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	43	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	56	57	56	57	56	60	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100

Female, Non-Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female, Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	94	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	96	97	98	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	96	98	99	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	97	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100

Female, Smoker

Issue Age	Duration 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Regulation 4-1-10 Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits

Section 1. Authority

Section 2. Basis and Purpose

Section 3. Definitions

Section 4. 2001 CSO Mortality Table

Section 5. Conditions

Section 6. Applicability of the 2001 CSO Mortality Table to Colorado Regulation 4-1-9

Section 7. Gender-Blended Tables

Section 8. Enforcement

Section 9. Severability

Section 10. Effective Date

Section 11. History

Section 1. Authority

This regulation is promulgated by the Commissioner of Insurance pursuant to § § 10-1-108(7), 10-1-109(1), 10-7-305.1(8)(f), and 10-7-309(l)(a)(m), Colorado Revised Statutes (C.R.S.).

Section 2. Basis and Purpose

The purpose of this regulation is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with § § 10-7-309(1), 10-7-305.1(8)(0, and 10-7-313, C.R.S., and Sections 5(A) and 5(B) of Colorado Regulation 4-1-9.

Section 3. Definitions

A. "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). This table may also be found in Appendix A of the Final Report of the American Academy of Actuaries' Commissioners Standard Ordinary Task Force, dated June 2002. No other amendments or revisions of this table, after this date, are authorized in this regulation.

For information as to how this table may be obtained or examined, please contact the Chief Actuary, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver CO, 80202. A copy of the table has been provided to the state publications depository library and is available for review at the library.

Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

B. "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

C. "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

D. "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

E. "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

Section 4. 2001 CSO Mortality Table

A. At the election of the company, for any one or more specified plans of insurance and subject to the conditions stated in this regulation, the 2001 CSO Mortality Table may be used as the minimum

standard for policies issued on or after February 1,2004, and before the date specified in Subsection B, to which § § 10-7-309(l)(a)(III) and 10-7-305.1(8)(f), C.R.S., and Sections 5(A) and 5(B) of Colorado Regulation 4-1-9 are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

B. Subject to the conditions stated in this regulation, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1,2009, to which § § 10-7-309(l)(a)(III) and 10-7-305.1(8)(f), C.R.S. and Sections 5(A) and 5(B) of Colorado Regulation 4-1-9 are applicable.

C. It should be noted that there is no new Commissioners Extended Term (CET) Table being proposed to replace the 1980 CET Table. Therefore, the new minimum basis for the computation of values related to extended term benefits will be the 2001 CSO Mortality Table.

Section 5. Conditions

A. For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

(1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by § 10-7-313, C.R.S., and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(3) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of Section 6 and § 10-7-305.1, C.R.S., relative to use of the select and ultimate form.

D. When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in Sections 5(C) of Colorado Regulation 3-1-8. The commissioner may exempt a company from this requirement if it only does life insurance business in this state and in no other state.

Section 6. Applicability of the 2001 CSO Mortality Table to Colorado Regulation 4-1-9

A. The 2001 CSO Mortality Table may be used in applying Colorado Regulation 4-1-9 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in Section 4 of this regulation (unless otherwise noted, the references in this section are to Colorado Regulation 4-1-9.)

(1) Section 3A(2)(b): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(2) Section 4B: All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the

optional minimum mortality standard for deficiency reserves stipulated in Section 6A(4) of this regulation. The value of "q(x+k+t-l)" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(3) Section 5A: The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(4) Section 5B: The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in Sections 5B(3)(a) to (i). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant Actuarial Standards of Practice.

(5) Section 6C: The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

(6) Section 6E(4): The calculations specified in Section 6E shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(7) Section 6F(4): The calculations specified in Section 6F shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(8) Section 6G(2): The calculations specified in Section 6G shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(9) Section 7A(l)(b): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

B. Nothing in this section shall be construed to expand the applicability of Colorado Regulation 4-1-9 to include life insurance policies exempted under Section 3 A of Colorado Regulation 4-1-9.

Section 7. Gender-Blended Tables

A. For any ordinary life insurance policy delivered or issued for delivery in this state on and after February 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection of this regulation.

B. The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002. This table may be found in Appendix J3 of the Final Report of the American Academy of Actuaries' Commissioners Standard Ordinary Task Force, dated June 2002. No other amendments or revisions of this table, after this date, are authorized in this regulation.

For information as to how this table may be obtained or examined, please contact the Chief Actuary, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver , CO, 80202. A copy of the table has been provided to the state publications depository library and is available for review at the library.

C. It shall not, in and of itself, be a violation of § 10-3-1104, C.R.S., for an insurer to issue the same kind

of policy of life insurance on both a sex-distinct and sex-neutral basis.

Section 8. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines, issuance of Cease & Desist Orders, and/or other suspensions or revocations of license.

Section 9. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Section 10. Effective Date

The effective date of this regulation is February 1, 2004.

Section 11. History

New regulation effective February 1, 2004.

REGULATION 4-1-11 Concerning Senior Protection in Annuity Transactions

Section 1. Authority

This regulation is issued under the authority of Sections 10-1-109 and 10-3-1110(1), Colorado Revised Statutes.

Section 2. Purpose and Background

The purpose of this regulation is to set forth standards and procedures for recommendations to senior consumers that result in a transaction involving annuity products so that the insurance needs and financial objectives of senior consumers at the time of the transaction are appropriately addressed.

Section 3. Applicability and Scope

A. This regulation shall apply to any recommendation to purchase or exchange an annuity made to a senior consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase or exchange recommended.

B. Unless otherwise specifically included, this regulation shall not apply to recommendations involving:

1. Direct response solicitations where there is no recommendation based on information collected from the senior consumer pursuant to this regulation;

2. Contracts used to fund:

(a) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(b) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;

(c) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(e) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(f) Formal prepaid funeral contracts.

C. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Section 4. Definitions

A. “Annuity” means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.

B. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

C. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

D. “Recommendation” means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual senior consumer that results in a purchase or exchange of an annuity in accordance with that advice.

E. “Senior consumer” means a person sixty-five (65) years of age or older. In the event of a joint purchase by more than one party, the purchaser will be considered to be a senior consumer if any of the parties is age sixty-five (65) or older.

Section 5. Duties of Insurers and of Insurance Producers

A. In recommending to a senior consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the senior consumer on the basis of the facts disclosed by the senior consumer as to his or her investments and other insurance products and as to his or her financial situation and needs.

B. Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

(1) The senior consumer's financial status;

(2) The senior consumer's tax status;

(3) The senior consumer's investment objectives; and

(4) Such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the senior consumer.

C.

(1) Except as provided under Paragraph (2) of this subsection, neither an insurance producer, nor an insurer where no producer is involved, shall have any obligation to a senior consumer under Subsection A related to any recommendation if a consumer:

(a) Refuses to provide relevant information requested by the insurer or insurance producer;

(b) Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; or

(c) Fails to provide complete or accurate information.

(2) An insurer or insurance producer's recommendation subject to Paragraph (1) shall be reasonable under all the circumstances actually known to the insurer or insurance producer at the time of the recommendation.

D.

(1) An insurer either shall assure that a system to supervise recommendations that is reasonably designed to achieve compliance with this regulation is established and maintained by complying with Paragraphs (3) to (5) of this subsection, or shall establish and maintain such a system, including, but not limited to:

(a) Maintaining written procedures; and

(b) Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this regulation.

(2) A general agent and independent agency either shall adopt a system established by an insurer to supervise recommendations of its insurance producers that is reasonably designed to achieve compliance with this regulation, or shall establish and maintain such a system, including, but not limited to:

(a) Maintaining written procedures; and

(b) Conducting periodic reviews of records that are reasonably designed to assist in detecting and preventing violations of this regulation.

(3) An insurer may contract with a third party, including a general agent or independent agency, to establish and maintain a system of supervision as required by Paragraph (1) with respect to insurance producers under contract with or employed by the third party.

(4) An insurer shall make reasonable inquiry to assure that the third party contracting under Paragraph (3) of this subsection is performing the functions required under Paragraph (1) of this subsection and shall take such action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following:

(a) The insurer annually obtains a certification from a third party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions; and

(b) The insurer, based on reasonable selection criteria, periodically selects third parties contracting under Paragraph (3) of this subsection for a review to determine whether the third parties are performing the required functions. The insurer shall perform those procedures to conduct the review that are reasonable under the circumstances.

(5) An insurer that contracts with a third party pursuant to Paragraph (3) of this subsection and that complies with the requirements to supervise in Paragraph (4) of this subsection shall have fulfilled its responsibilities under Paragraph (1) of this subsection.

(6) An insurer, general agent or independent agency is not required by Paragraph (1) or (2) of this subsection to:

(a) Review, or provide for review of, all insurance producer solicited transactions; or

(b) Include in its system of supervision an insurance producer's recommendations to senior consumers of products other than the annuities offered by the insurer, general agent or independent agency.

(7) A general agent or independent agency contracting with an insurer pursuant to Paragraph (3) of this subsection shall promptly, when requested by the insurer pursuant to Paragraph (4) of this subsection, give a certification as described in Paragraph (4) of this subsection or give a clear statement that it is unable to meet the certification criteria.

(8) No person may provide a certification under Paragraph (4)(a) of this subsection unless:

(a) The person is a senior manager with responsibility for the delegated functions; and

(b) The person has a reasonable basis for making the certification.

E. Compliance with the National Association of Securities Dealers Conduct Rules pertaining to suitability shall satisfy the requirements under this section for the recommendation of variable annuities. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce the provisions of this regulation.

Section 6. Recordkeeping

A. Insurers, general agents, independent agencies and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the senior consumer and other information used in making the recommendations that were the basis for insurance transactions for five years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

B. Records that are required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Section 7. Enforcement

A. Mitigation of Responsibility

1. The Commissioner may order:

(a) An insurer to take reasonable appropriate corrective action for any senior consumer harmed by the insurer's, or by its insurance producer's violation of this regulation;

(b) An insurance producer to take reasonably appropriate corrective action for any senior consumer harmed by the insurance producer's violation of this regulation; and

(c) A general agency or independent agency that employs or contracts with an insurance producer to sell, or solicit the sale, of annuities to senior consumers, to take reasonably appropriate corrective action for any senior consumer harmed by the insurance producer's violation of this regulation

2. Any applicable penalty under Sections 7. Enforcement for a violation of Section 5 of this Regulation may be reduced or eliminated if corrective action for the senior consumer was taken promptly after a violation was discovered.

B. Noncompliance with this regulation may result, after proper notice, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines, issuance of Cease & Desist Orders, and/or suspensions or revocations of license.

Section 8. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application for such provision to other persons or circumstances shall not be affected thereby.

Section 9. Effective Date

This regulation shall be effective for policies issued or renewed on or after October 1, 2004.

Section 10 History

Original regulation effective October 1, 2004.

Repromulgated Regulation 4-2-1 - Replacement of Accident and Sickness Insurance

Section 1. Authority

This amended regulation is promulgated under the authority of § § 10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.).

Section 1 Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 3. Applicability

This regulation shall apply to individual accident and sickness insurance (except Medicare supplement insurance, conversion to an individual or family policy from a group, blanket 01 group type policy, or any other insurance that is covered by a separate state statute).

Section 4. Definitions

A. "Accident and sickness insurance" means a policy, plan, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued hi connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. An accident and sickness insurance policy does not include a Medicare supplement insurance policy, or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute.

B "Direct response" means a solicitation through a sponsoring or endorsing entity or individually solely through mail, telephone, the Internet or other mass communication media.

Section 5. Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as

of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(1) Do you have another insurance policy or contract in force?

(a) If so, with which company?

(b) If so, do you intend to replace your current accident and sickness insurance with this policy (contract)?

(2) Do you have any other accident and sickness insurance that provides benefit similar to this accident and sickness policy?

(a) If so, with which company?

(b) What kind of policy?

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefit?

B. Producers shall list any other accident and sickness insurance they have sold to the applicant

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. In the case of a direct response insurer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of accident and sickness insurance, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, a notice regarding replacement of accident and sickness insurance. One (1) copy of such notice signed by the applicant and producer, except where the coverage is old without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of issuance of the policy, The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance, located in Appendix A of this regulation.

E. The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) required by Subsection D above for an issuer, shall be provided in the format prescribed and adopted by the Commissioner of Insurance.

F. Paragraphs 1 and 2, contained in such Notice to the Applicant Regarding Replacement of Accident and Sickness Insurance, (applicable to preexisting conditions), in Appendix A, may be deleted by the issuer if the replacement does not involve the application of a new preexisting condition limitation.

G. Failure to comply with the requirements of this Section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under § 10-3-1104, C.R.S.

Section 6. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license.

Section 7. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 8. Effective Date

This regulation is effective February 1, 2001.

Section 9. History

Originally issued as Regulation 74-2, effective March 15, 1974.

Amended December 22,1975, effective January 1, 1976.

Amended effective January 14, 1977.

Amended effective January 14, 1977.

Renumbered on June 1, 1992.

Repealed and Repromulgated in full, effective February 1, 2001.

Appendix A Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

[Insurance company's name and address)

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide [Number days of free look period, if any] days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will net duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other, (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. It you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or contract is guaranteed issued this paragraph need not appear].

Do not cancel your present policy until you have received your new policy and are sure mat you want to keep it

_____(Signature of Producer or Other Representative)*[Typed Name and Address of Issuer or Producer]

_____(Applicants Signature)

_____(Date)

*Signature not required for direct response sales.

Repealed and Repromulgated Regulation 4-2-2 (In Full) Hospital Indemnity and Disability Income Policies

Section 1. Authority

This regulation is issued based upon the authority granted the commissioner under § 10-1-109 and 10-16- 109, C.R.S.

Section 2. Purpose

This regulation prohibits insurers from refusing to pay benefits under certain contracts because of hospitalization m government hospitals.

Section 3. Scope

This regulation applies to all hospital, indemnity and disability income policies , contracts, riders, endorsements, etc, which provides benefits because of hospitalization or disability originating out of hospitalization hereinafter referred to as hospital indemnity and disability income policies. It does not apply to hospital expense policies.

Section 4. Definitions

For the purposes of this regulation:

A. "Disability income policy" means a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury.

B. "Government hospital" means any hospital under governmental control whether federal, state, county or city. It includes Veterans Administration hospitals.

C. "Hospital indemnity policy" means a policy that provides a stated daily, weekly or monthly payment while the insured is hospitalized, regardless of expenses incurred and regardless of whether or not other insurance is in force. The insured can use the daily, weekly or monthly benefit as (s)he chooses, for hospital or other expenses.

Section 5. Rules

All hospital indemnity and disability income policies delivered or issued for delivery in the State of Colorado winch provide benefits predicated on hospitalization will not in any way deny such benefits on the basis that such hospitalization was in a government hospital.

Section 6. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 7. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 8. Effective Date

This regulation as amended shall become effective January 1, 2001.

Section 9. History

Originally issued as Regulation 74-4, effective July 1, 1974.

Renumbered as Regulation 4-2-2, effective June 1, 1991

Repealed and Repromulgated in full, effective January 1, 2001.

Amended Regulation 4-2-3 Advertisements Of Accident And Sickness Insurance

Section 1. Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.).

Section 2. Purpose

The purpose of this regulation is to establish minimum criteria to assure proper and accurate description and to protect prospective purchasers with respect to the advertisement of accident and sickness insurance in the same manner as the regulation governing advertisements of Medicare supplement insurance. This regulation assures the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as accident and sickness insurance by the establishment of standards of conduct in the advertising of accident and sickness insurance in a manner that prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.

Section 3. Applicability

A. This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 4, subsections B, G, H and I unless otherwise specified in this regulation, which the insurer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, producer or solicitor, as those terms are defined in the Insurance Code of this state.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised.

C. Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Section 4. Definitions

A.

(1) “Accident and sickness insurance policy” means a policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits or medical, surgical or hospital benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. An accident and sickness insurance policy does not include a Medicare supplement insurance policy, or any other type of accident and sickness insurance with advertising guidelines covered by a separate statute and/or regulation.

(2) The language “except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts” means it does not include disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental to the above contracts that contain only provisions that:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.

B.

(1) “Advertisement” means:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other Internet displays or communications, oilier forms of electronic communications, billboards and similar displays;

(b) Descriptive literature and sales aids of all kinds issued by an insurer, producer, or solicitor for presentation to members of the insurance-buying public, such as circulars, leaflets, booklets, depictions, illustrations, form letters and lead-generating devices of all kinds; and

(c) Prepared sales talks, presentations and material for use by producers and solicitors whether prepared by the insurer, producer or solicitor.

(2) The definition of “advertisement” includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

(3) The definition of “advertisement” extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to the use of all media for communications by insurers, producers and solicitors.

(4) The definition of advertisement does not include:

(a) Material used solely for the training and education of an insurer's employees or producers;

(b) Material used in-house by insurers;

(c) Communications within an insurer's own organization not intended for dissemination to the public;

(d) Individual communications of a personal nature with current policyholders other than material urging the policyholders to increase or expand coverages;

(e) Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

(f) Court-approved material ordered by a court to be disseminated to policyholders; or

(g) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided that the announcement clearly indicates that it is preliminary to the issuance of a booklet and that the announcement does not describe the specific benefits under the contract or program nor describe advantages as to the purchase of the contract or program. This does not prohibit a general endorsement of the program by the sponsor.

C. "Certificate" means a statement of the coverage and provisions of a group accident and sickness insurance policy, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

D. "Exception" means any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

E. "Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

F. "Invitation to contract" means an advertisement that is neither an "invitation to inquire" nor an "institutional advertisement."

G. "Invitation to inquire" means:

(1) An advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable, but may contain:

(a) The dollar amount of benefits payable; and

(b) The period of time during which benefits are payable.

(2) An "invitation to inquire" may not refer to cost.

(3) An "invitation to inquire" shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance producer or the company [whichever is

applicable]."

H. "Lead-generating device" means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of accident and sickness insurance.

I. "Limitation" means a provision that restricts coverage under the policy other than an exception or a reduction.

J. "Limited benefit health coverage" means a health policy, contract, or certificate offered or marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments, or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term hospital and medical expense policies, contracts or certificates, or catastrophic health policies, contracts, or certificates. Such nonsupplemental plans are included under the term "health benefit plan" as defined in Section 10-16-102(21)(b), C.R.S.

This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance.

K. "Prominently" or "conspicuously" means that the information to be disclosed "prominently" or "conspicuously" will be presented in a manner that is noticeably set .apart from other information or images in the advertisement.

L. "Reduction" means a provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable, had the reduction not been used.

Section 5. Method of Disclosure of Required Information

All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which theinformation relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of the following methods of disclosure:

A. Disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits; or

B. Disclosure not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions Not Covered," and "Exceptions and Reductions." The use of captions such as the following are prohibited because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions," or "Minimum Limitations."

Section 6. Form and Content of Advertisements

A. The format and content of an advertisement of an accident and sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions.

B. Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation.

C. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed.

D. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

E. An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words “insurance policy” or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

F. An insurer, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement:

(1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or

(2) Otherwise violates the provisions of this regulation.

G. An insurer, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or represertative capacity of the person or the true purpose of the advertisement.

Section 7. Advertisements of Benefits Payable, Losses Covered or Premiums Payable

A. Covered Benefits.

(1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited.

(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited.

(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(4) An advertisement shall not contain or use words or phrases such as “all,” “full,” “complete,”

"comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income" (when used to express loss of time benefits) or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy.

(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with tin's regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you," or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.

(6)

(a) An advertisement for basic hospital expense coverage, basic medical- surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited if:

(i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without, also in the same headline, a lead-in or caption specifying the applicable daily limits and other internal limits;

(ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or

(iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.

(b) This paragraph 6 does not apply to individual major medical expense coverage, individual basic medical expense coverage, or disability income insurance.

(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited unless the actual amounts payable per day for the indemnity or benefits are stated.

(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid for an average claim.

(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited.

(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited.

(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as “low,” “low cost,” “budget” or use qualifying words of similar import. The use of words such as “only” and “just” in conjunction with statements of premium amounts when used to imply a bargain are prohibited.

(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited unless the advertised policies expressly provide that the premiums will not be changed in the future.

(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective.

(14) An advertisement that exaggerates the effects of statutorily mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited.

(15) An advertisement that implies that a common type of policy or a comb nation of common benefits is “new,” “unique,” “a bonus,” “a breakthrough,” or is otherwise unusual is prohibited. The addition of a novel method of premium payment to ;m otherwise common plan of insurance does not render it new.

(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is: not the fact, is prohibited.

(17) An advertisement that contains statements such as “anyone can apply,” or “anyone can join,” other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited.

(18) An advertisement that states or implies immediate coverage of a policy is prohibited unless administrative procedures exist so that the policy is issued within fifteen (15) working days after the insurer receives the completed application.

(19) An advertisement that contains statements such as “here is all you do 1o apply,” or “simply” or “merely” to refer to the act of applying for a policy that is not a guaranteed issue policy is prohibited unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance producer will call and no commissions will be paid to producers that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response.

(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services.

(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited.

(23) An advertisement that uses words such as “extra,” “special” or “added” to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as “tax-free,” “extra cash,” “extra income,” “extra pay,” or substantially similar words or phrases because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term “juxtaposition” means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement.

(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.

(27) An advertisement of a specified disease policy providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount for expenses. Instead, the term “charges” or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses.

(28) An advertisement that describes any benefits that vary by age shall disclose that fact.

(29) An advertisement that uses a phrase such as “no age limit,” if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact.

(30) A television, radio, internet, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or e- mail or to call the company or a subsequent advertisement prior to contact shall include information disclosing that a producer may contact the applicant.

(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

(32) An advertisement, including invitations to inquire or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are:

(a) The use of phrases such as “cancer kills somebody every two minutes” and “total number of accidents” without reference to the total population from which the statistics are drawn;

(b) The exaggeration of the importance of diseases rarely or seldom found in the class of

persons to whom the policy is offered;

(c) The use of phrases such as “the finest kind of treatment,” implying that the treatment would be unavailable without insurance;

(d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;

(e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills;

(f) The use of phrases such as “financial disaster,” “financial distress,” “financial shock,” or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement;

(g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and

(h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly.

B. Exceptions, Reductions and Limitations

(1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a “benefit builder” or stating “even preexisting conditions are covered after two years.” Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered.

(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of such periods.

(4) An advertisement shall not use the words “only,” “just,” “merely,” “minimum,” “necessary” or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: “This policy is subject to the following minimum exceptions and reductions.”

(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited.

(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact.

(7) An advertisement that refers to “hospitalization for injury or sickness” omitting the word “covered” when the policy excludes certain sicknesses or injuries, or that refers to “whenever you are hospitalized,” “when you go to the hospital” or “while you are confined in the hospital” omitting the phrase “for covered injury or sickness,” if the policy excludes certain injuries or sicknesses, is prohibited. Continued reference to “covered injury or sickness” is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.

(8) An advertisement that fails to disclose that the definition of “hospital” does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited.

(9) The term “confining sickness” shall be explained in an advertisement containing the term. The explanation might be as follows: “Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors.” Captions such as “Lifetime Sickness Benefits” or “Five-Year Sickness Benefits” are incomplete if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as “Lifetime House Confining Sickness Benefits” or “Five-Year House Confining Sickness Benefits” would be permissible.

(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited.

(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: “THIS IS A LIMITED POLICY,” “THIS POLICY PROVIDES LIMITED BENEFITS,” or “THIS IS A CANCER ONLY POLICY.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisiement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner that does not minimize, render obscure or otherwise make them appear unimportant.

C. Preexisting Conditions

(1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term “preexisting condition” without an appropriate definition or description shall not be used.

Negative features must be accurately set forth. Any limitation on benefits including preexisting conditions also must be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed elsewhere h the advertisement.

(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase “no medical examination required” and phrases of similar import, but does not prohibit

explaining “guaranteed issue.” If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows:

“Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past?

“YES”

Or substantially the following statement:

“Iunderstand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past.”

Section 8. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

A. An advertisement that is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions.

B. Advertisements of cancellable accident and sickness insurance policies shall state that the contract is cancellable or renewable at the option of the company, as the case may be: A policy that is renewable at the option of the insurance company shall use language substantially similar to the following: “This policy is renewable at the option of the company,” or “The company has the right to refuse renewal of this policy,” or “Renewable at the option of the insurer,” or “This policy can be cancelled by the company at any time.”

C. Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates if the policy so provides.

D. Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums, and (3) the establishment of aggregate limits.

(1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth.

(2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase.

Section 9. Standards for Marketing

A. An insurer, directly or through its producers or solicitors, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its producers or solicitors will be fair and accurate;

(2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and

(3) Establish auditable procedures for verifying compliance with this subsection.

B. The following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies, or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer;

(2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

(3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

Section 10. Testimonials or Endorsements by Third Parties

A. Testimonials and/or endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all of the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:

(1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;

(2) Has been formed by the insurer, is owned or controlled by the insurer, its employees, or the person or persons who own or control the insurer;

(3) Has any person in a policy-making position who is affiliated with the insurer .in any of the above described capacities; or

(4) Is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. Any person or agency acting as a spokesperson, as defined in the preceding paragraph, who performs any of the following acts in an advertisement shall be considered soliciting an insurance product, and such person or agency shall be a licensed insurance producer or agency pursuant

to the Colorado Insurance Laws:

(1) Individual who solicits, negotiates, effects, procures, delivers, renews, continues or binds; or

(2) A corporation, partnership, association, or other legal entity transacting the business of insurance.

D. The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: “Paid Endorsement.” The requirement of this disclosure may be fulfilled by use of the phrase “Paid Endorsement” or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence.

E. The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made cm behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances.

F. An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

G. When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

Section 11. Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised unless that is the fact, and when applicable to other policies or plans, shall specifically so state.

(1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data does not relate to the policy being advertised.

(2) An advertisement using statistics that describe an insurer, such as asses, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the

potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous,” or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in the advertisement.

Section 12. Identification of Plan or Number of Policies

A. An advertisement that uses the word “plan” without prominently identifying it as an accident and sickness insurance policy is prohibited.

B. When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

C. When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies.

Section 13. Disparaging Comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

A. An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits.”

B. Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages.

C. Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited.

Section 14. Jurisdictional Licensing and Status of Insurer

A. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as “official” or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public.

C. An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

Section 15. Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. An advertisement shall not use any combination of words, symbols, or physical materials that by their content, .phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted if they may lead the public to believe:

(1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

(2) That the advertiser is the same as is connected with or is endorsed by the governmental agencies or the other insurers.

D. An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description.

E. An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

F. An advertisement may not incorporate the word “Medicare” in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase “[ ] Medicare Department of the [ ] Insurance Company,” or language of similar import.

G. An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement.

H. The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark.

I. The use of the name of an agency or “[ ] Underwriters” or “[ ] Plan” in type, size and location so as to

have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

J. The use of an address so as to mislead or deceive as to true identity of the insurer, its location or licensing status is prohibited.

K. An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

L. Advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before they may be used.

M. A producer who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. A producer or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation.

Section 16. Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact.

B. This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status, entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

C. Advertisements that indicate that a particular coverage or policy is exclusively for “preferred risks” or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

D. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as “enroll” or “join” to imply group or blanket insurance coverage when that is not the fact.

Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

Section 17. Introductory, Initial or Special Offers

A.

(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the

offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as “special,” “limited,” or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than ten (10) days and not more than forty (40) days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control.

(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact.

(4) The phrase “a particular insurance product” in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

C. Special awards, such as a “safe drivers' award,” shall not be used in connection with advertisements of accident and sickness insurance.

Section 18. Statements about an Insurer

An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

Section 19. Enforcement Procedures

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed,

published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

Section 20. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license. Failure to comply with the requirements of this regulation constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under § 10-3- 1104,C.R.S.

Section 21. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 22. Effective Date

This regulation is effective February 1, 2003.

Section 23. History

Originally issued as Regulation 75-2, effective December 22, 1975.

Renumbered as Regulation 4-2-3, effective June 1, 1992.

Amended Regulation, effective July 1, 1993.

Repealed and Repromulgated in full, effective February 1, 2001.

Amended Regulation, effective August 1, 2001.

Amended Regulation, effecive February 1, 2003.

Amended Regulation 4-2-5 Hospital Definition

Section 1. Authority

Section 2. Purpose

Section 3. Scope

Section 4. Definitions

Section 5. Enforcement

Section 6. Severability

Section 7. Effective Date

Section 8. History

Section 1. Authority

This amended regulation is promulgated under the authority of § 10-1-109 C.R.S.

Section 2. Purpose

The purpose of this regulation is to standardize the definition of "hospital" used in sickness and accident insurance policy forms in this state to ensure the adequate provision of inpatient health care services.

Section 3. Scope

This regulation shall apply to all entities marketing or selling policies of sickness and accident insurance within the State of Colorado which provide coverage for inpatient health care services at a hospital; except this regulation does not include a Medicare supplement insurance policies and a waiver of premium or double indemnity benefit included in a life insurance policy or annuity contract

Section 4. Definitions

"Hospital" means a hospital currently licensed or certified by the department of public health and environment pursuant to the department's authority under section 25-1-107 (1) (1). This definition shall not be construed to create coverage for any health care service that is not otherwise covered under the terms of the sickness and accident insurance policy.

Section 5. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, int the imposition of any sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and/or suspension or revocation of license.

Section 6. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 7. Effective Date

This regulation as amended is effective January 1, 2001.

Section 8. History

Originally issued as Regulation 76-6, effective January 14, 1977.

Renumbered as Colorado Regulation 4-2-5 on June 1, 1992.

Amended Regulation effective March 1, 1994.

Amended Regulation effective January 1, 2001.

Amended Regulation 4-2-6 Concerning The Definition Of The Term "Complications Of Pregnancy" For Use In Accident And Health Insurance Policies

Section 1. Authority

Section 1. Authority

This amended regulation is promulgated under the authority granted to the Commissioner of Insurance under Sections 10-1-109, 10-16-109 and 10-3-1110, C.R.S.

Section 2. Purpose

The purpose of this regulation is to standardize the definition of the term “complications of pregnancy” as employed in sickness and accident insurance policies covering residents of this state consistent with the commonly perceived connotation of this term by the general public.

Section 3. Scope

This regulation shall apply to all entities marketing or selling policies of sickness and accident insurance within the State of Colorado; except that this regulation win not apply to Medicare supplement insurance policies and a waiver of premium or double indemnity benefit included in a life insurance policy or annuity contract.

Section 4. Definitions

For the purposes of this regulation “Complications of pregnancy” shall mean:

(1) Conditions (when the pregnancy is not terminated) pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;

(2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Section 5. Rules

All insurers marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado shall employ in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive man that required by this

regulation.

NOTE: All insurers, nonprofit hospital and health service corporations under 10-16-101, et seq., C.R.S., marketing group sickness and accident coverage within the State of Colorado should be aware that both the Colorado Civil Rights Commission, pursuant to 24-34-402(1) and (3(, C.R.S., and the Federal Equal Employment Opportunity Commission, in accordance with 42 U.S.C. 2000 e(k), require that all such coverage provided to the employees as an employment benefit treat a normal pregnancy the same as a sickness.

Section 6. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 7. Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 8. Effective Date

This amended regulation shall become effective November 1, 2000.

Section 9. History

Originally issued as Regulation 78-16, effective June 30, 1979.

Amended Regulation 78-16, effective October 1, 1983.

Renumbered as Regulation 4-2-6, effective June 1, 1992.

Amended effective November 1, 2000.

Amended Regulation 4-2-8 Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care

Section 10. History

Section 1. Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-16-104(8)(d), Colorado Revised Statutes (C.R.S.).

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.

Section 3. Scope

The requirements of this regulation shall apply to:

A. Insurers subject to the provisions of Part 2 of Article 16 of Title 10, C.R.S. and non-profit hospital, medical surgical, and health service corporations subject to the provisions of Part 3 of Article 16 of Title 10, C.R.S., which provide: hospital, surgical or major medical coverage on an expense incurred basis, except as noted in paragraph B below, issued on or after the effective date hereof and to all such policies renewed after said date, unless the insurer certifies in writing to the Commissioner of Insurance that it no longer issues the type of policy being renewed. “Renewed” or “renewal” means to continue coverage for an additional policy period upon expiration of the current policy period of a policy.

B. This regulation does not apply to the following:

(1) Medicare supplement policies issued under § 10-18-101 et seq., C.R.S.;

(2) Credit accident and health policies issued under § 10-10-101 et seq., C.R.S.; and

(3) Any insurance policy, contracts or certificate which provides coverage exclusively for.

(a) Disability loss of income;

(b) Dental services;

(c) Optical services;

(d) Hospital confinement indemnity,

(e) Accident only; or

(f) Prescription drug services.

Section 4. Requirements for Home Health Services

A. Definitions.

(1) “Home health agency” means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVII of the Federal “Social Security Act” , as amended, for home health agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.

(2) “Home health services” means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

(a) Professional nursing services;

(b) Certified nurse aide services, as defined in § 12-38.1-102(3), C.R.S.;

(c) Medical supplies, equipment and appliances suitable for use in the home; and

(d) Physical therapy, occupational therapy or speech pathology and audiology services, as such therapy and services are defined in C.R.S.

(3) “Home health visit” is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to 4 hours by a home health aide shall be considered as one visit.

(4) “Medical social services” are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. Prior hospitalization shall not be required.

(2) The policy offering shall require, as a condition of coverage that home health care services are to be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health care provider.

(3) The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services, review of treatment at periodic intervals and certification by the physician that confinement in a hospital or skilled nursing facility would be required in the absence of home health services.

(4) The policy may require that all home health services included in the plan of care be coordinated by the home health agency.

C. Benefits for Home Health Care Services.

(1) Benefits levels for home health care services shall not be less than the deductible, coinsurance and stop loss provisions of the overall policy or certificate.

(2) The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than 60 home health visits in any calendar year.

(3) The policy offered shall include benefits for the following services:

(a) Professional nursing services provided by a Registered Nurse;

(b) Certified nurse aide services under the supervision of a Registered Nurse or a qualified therapist;

(c) Physical therapy;

(d) Occupational therapy;

(e) Speech therapy and audiology,

(f) Respiratory and inhalation therapy,

(g) Nutrition counseling by a nutritionist or dietitian;

(h) Medical social services;

(i) Medical supplies;

(j) Prosthesis and orthopedic appliances;

(k) Rental or purchase of durable medical equipment; and

(l) Drugs, medicines, or insulin.

(4) The services identified in (C)(3)(i) through (C)(3)(1) above may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

D. Limitations and Exclusions.

(1) Benefits for home health services may be governed by policy or certificate limitations and exclusions, including but not limited to, exclusion for non-skilled personal care and conditions for surgery excluded in the policy or certificate.

(2) The following items need not be considered as eligible expenses under home health care benefits:

(a) Services or supplies for personal comfort or convenience, including homemaker services;

(b) Services related to well-baby care; and

(c) Food services or meals other than dietary counseling.

Section 5. Requirements for Hospice Care

A. Definitions.

(1) A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. Hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

(2) "Hospice care" is an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the

patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient Hospice care is not limited to medical intervention, but addresses physical, social, psychological, and spiritual needs of the patient Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

(3) A "patient" is an individual in the terminal stage of illness who has an anticipated life expectancy of six months or less and who alone or in conjunction with a family member or members, has voluntarily requested admission and been accepted into a hospice.

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.

(5) "Palliative services" are those services and/or interventions which are not curative but which produce the greatest degree of relief from pain and other symptoms of the terminal illness.

(6) The "interdisciplinary team" is a group of qualified individuals, which shall include, but is not limited to, a physician, registered nurse, clergy/counselors, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.

(7) "Core services" are physician services, nursing services, pastoral counseling, trained volunteers, and social/counseling services routinely provided by hospice staff or volunteers.

(8) "Social/counseling services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience.

(9) "Personal care" means services provided to a patient in his or her home to meet the patient's physical requirements and/or to accommodate a patient's maintenance or supportive needs.

(10) "Homemaker services" means services provided the patient which include:

(a) General household activities including the preparation of meals and routine household care; and

(b) Teaching, demonstrating and providing patient/family with household management techniques that promote self-care, independent living and good nutrition.

(11) "Hospice staff" shall include volunteers and paid persons.

(12) "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

(13) "Inpatient services" are hospice services provided to patient/families who require 24 hour nursing supervision in a licensed hospice facility or other licensed health facility. In the event that a hospice provides inpatient services in a licensed health facility other than a hospice, such hospice shall maintain administrative control of and responsibility for the provision of all hospice services.

(14) “Hospice day care” means health and social services provided on a regularly scheduled basis in a day care center governed by the licensed hospice to insure the overall continuum of patient care.

(15) “Hospice levels of care:”

(a) “Routine home care:” The level of care a patient/family receives according to the interdisciplinary team's plan of care each day the patient is at home and not receiving continuous home care.

(b) “Continuous home care:” The level of care received by the patient during a period of medical crisis to achieve palliation and management of acute medical symptoms. The preponderance of care must be nursing care (at least half) and care must be provided for a period of at least eight hours in one calendar day. Home health aide and homemaker services, or both, may be provided to supplement nursing care.

(c) “Inpatient hospice respite care:” The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief Inpatient respite care may be provided only on an intermittent, non- routine, short-term basis. It may be limited to periods of five days or less,

(d) “General inpatient hospice care:” The level of care the patient receives when short-term inpatient care for pain control or acute symptom management cannot be achieved in the home. This level of care must be provided in a licensed facility with the approval of the physician and the hospice.

(16) “Bereavement” is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

(17) An “inpatient hospice facility” is one, which shall directly provide inpatient services and may provide any or all of the continuum of hospice services as described in (5)(A)(1). These services are provided 24 hours a day and, to the extent possible, in a homelike setting.

(18) A “benefit period” for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A “hospice per diem” rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

(20) An “unrelated illness” is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

(21) “Evaluation” means an objective, formal and cyclical assessment of the functioning of the organization and of the provision of hospice care.

B. General Provisions Pertaining to Hospice Care.

(1) The policy offering shall provide mat hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of me location or facility in which such services are furnished

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except mat benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

(3) The policy offering shall require a physician's certification of the patient's illness, including a prognosis for life expectancy and the appropriateness for hospice care. The insurer may also require a copy of the patient's plan of care and any changes made to the level of care or to the plan of care.

(4) The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of care at periodic intervals.

(5) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services.

(1) Benefits for hospice care services shall be governed by the deductible, coinsurance and stop-loss provisions of the overall policy or certificate. The details of these provisions will be forwarded and updated to the provider upon authorization of benefits.

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. Any policy offered shall provide a benefit of no less than S100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services: and;

(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less man the per diem benefit multiplied by ninety-one (91) days.

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom

management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day,

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

D. Limitations and Exclusions.

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage.

Section 6. Additional Requirements for Home Health Care Services and Hospice Care

A. The offer to a policyholder to purchase home health care and hospice care coverage must be in writing, either by means of a prominent statement or question on the application for the policy or on a separate form.

B. Nothing in this regulation shall prohibit the insurer from offering a higher level of benefits than required herein.

Section 7. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 8. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any

reason held to be invalid, the remainder of the regulation and the application of such provision shall not be affected thereby.

Section 9. Effective Date

The effective date of this regulation is February 1, 2001.

Section 10. History

Originally issued as Colorado Regulation 85-6, effective Oct 1, 1985.

Amended October 1, 1986.

Renumbered as Colorado Regulation 4-2-8, July 1, 1992.

Amended August 1, 1993.

Amended February 1, 1994.

Amended February 1, 2001.

Amended Regulation 4-2-9 Concerning Non-Discriminatory Treatment of Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus(HIV) Related Illness by Life and Health Carriers

Section 1 Authority

This amended regulation is promulgated under the authority of § 10-1-109, 1104.5(3)(d)(n) and 10-3-1110, C.R.S.

Section 2 Purpose

The purpose of this regulation is to establish standards that will assure non-discriminatory treatment with respect to AIDS and HIV infection in underwriting practices, policy forms and benefit provisions utilized by entities subject to the provisions of this regulation. It also establishes what HIV/AIDS medical tests permitted under §10-3-1104.5, C.R.S., are considered medically reliable for underwriting decisions.

Section 3 Scope

This regulation applies to all entities that provide life or health coverage in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident company, a life or annuity company, and any other entity providing a plan of life, annuity, health coverage or health benefits subject to the insurance laws and regulations of Colorado.

Section 4 Definitions

“Insurance Coverage” shall mean life insurance policies and health coverage plans. “Person” shall have the meaning in § 10-3-1104.5(2)(f), C.R.S.

Section 5 Standards

A. No person, their agent or employee shall make any inquiry or investigation to determine an insurance applicant's sexual orientation.

B. Sexual orientation may not be used in the underwriting process or in the determination of insurability.

C. Insurance support organizations shall be directed by insurers to not investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary. All persons shall give written notice to their agents and employees who conduct investigations of applicants for insurance coverage, that they shall not investigate, either directly or indirectly, the sexual orientation of an applicant or beneficiary.

D. No question shall be used which is designed to establish the sexual orientation of the applicant.

E. Questions relating to the applicant having or having been diagnosed as having AIDS or HIV infection are permissible if they are designed solely to establish the existence of the condition. For example, straightforward questions on applications are acceptable, such as, “Have you had or been told by a member of the medical profession that you have AIDS or HIV infection?” or “Have you received treatment from a member of the medical profession for AIDS or HIV infection?” are acceptable.

F. Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used as a proxy to establish the sexual orientation of the applicant, and the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application. For example: “Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands...” These types of questions should be related to a finite period of time preceding completion of the application and should be specific. Such questions should provide the applicant the opportunity to give a detailed explanation.

G. Insurers may not use an applicant's marital status, living arrangements, occupation, gender, medical history, beneficiary designation, or zip code or other territorial classification to establish, or aid in establishing, the applicant's sexual orientation.

H. For the purpose of rating an applicant for health and life insurance, a person may impose territorial rates only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

I. No adverse underwriting decision shall be made because medical records or any investigation or report indicates that the applicant has demonstrated AIDS or HIV infection related concerns by seeking counseling from health care professionals. Neither shall an adverse underwriting decision be

made on the basis of such AIDS or HIV infection related concerns unless a medical test which is a reliable predictor of infection, as defined in Section 5. J. below, has been administered. This subsection does not apply to an applicant seeking treatment and/or diagnosis.

J. Reliable predictors of infection are delineated in Section 10-3-1104.5(3)(d)(I), C.R.S. Pursuant to Section 10-3-1104.5 (3)(d)(II), C.R.S., the commissioner designates the following tests, approved by the Colorado Department of Public Health and Environment, as equally reliable predicters of AIDS OR HIV infection:

1. A positive HIV-1 p24 antigen test, as defined by the U.S. Department of Public Health and Human Services, Center for Disease Control and Prevention (The Mobidity and Mortality Weekly Report, Volume 95, March 1, 1996). A copy of this USDPHHS publication is on file at the Colorado Division of Insurance. This regulation does not include later editions or amendments to this USDPHHS report.

2. A positive licensed polymerase chain reaction assay for HIV levels in the serum.

3. Two positive or repeatedly reactive commercially licensed serum, oral fluid or urine ELISA or EIA tests and either:

   a. For serum or oral fluid specimens, a Western Blot test with bands present at any two of p24, gp41 or gpl20/gp160; or

   b. or urine specimens, a Western Blot test with bands present gp 160.

K. To be used for issuing or underwriting a policy, a test described in Section 5 J. must have been licensed by the U.S. Food and Drug Administration as of the effective date of this regulation. A list of such tests is attached as Exhibit 1.

L. If a specific test licensed by the U.S. Food and Drug Administration indicates the presence of the HIV infection or medical condition indicative of the HIV infection, the insurer shall, before relying on a single test result to deny or limit coverage or to rate the coverage, follow the U.S. Food and Drug Administration confirmation protocols licensed as of the effective date of this regulation and shall use any applicable confirmatory tests or series of tests licensed as of the effective date of this regulation by the U.S. Food and Drug Administration to confirm the indication. The confirmation protocols and applicable follow-up test regimens are attached as Exhibit 1.

M. If an applicant is required to take an AIDS or HIV infection test in connection with an application for life or health insurance, the use of such test must be revealed to the applicant and his or her written consent obtained. Test results shall be strictly confidential medical information. However, this regulation is not intended nor should it be interpreted as prohibiting reporting HIV infection to state and local departments of health as provided in Sections 25-4-1402 and 25-4-1403, C.R.S.

N. Persons subject to this regulation may include questions on applications as to whether or not the applicant has tested positive on an AIDS or HIV infection test. However, in the event of an affirmative response, no adverse underwriting decisions shall be made on the basis of such response unless it can be determined that the test protocols in Section 5. J. and K. above have been followed.

O. Insurance coverage which excludes or limits coverages for expenses related to the treatment of AIDS and HIV related illness or complications of AIDS, e.g., opportunistic infection resulting from AIDS, will not be approved for use in Colorado, except to the extent that such exclusions or limitations are consistent with the exclusions or limitations applicable to other covered illnesses or conditions covered by the policy or certificate.

Section 6 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws, which include the imposition of fines and suspension or revocation of license.

Section 7 Severability

If any provisions of this regulation or the application thereof to any person or circumstance are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 8 Effective Date

This regulation as amended is effective April 1, 2000.

Section 9. History

Originally issued as Regulation 87-2, effective January 1, 1988.

Renumbered as Regulation 4-2-9, effective June 1, 1992.

Amended Section IV(J), effective February 1,1995.

Amended Regulation, effective March 2, 1999.

Amended Regulation, effective April 1, 2000.

Exhibit 1 FDA Licensed/Approved HIV Tests for Colorado Regulation 4-2-9

Published as of 7/16/98

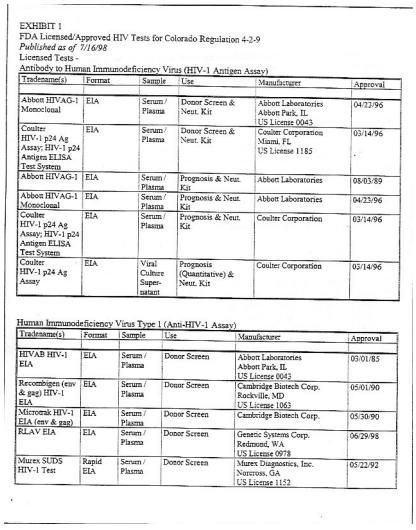

EXHIBIT 1
FDA Licensed/Approved HIV Tests for Colorado Regulation 4-2-9
Published as of 7/16/98
Licensed Tests -
Antibody to Human Immunodeficiency Virus (HIV-1 Antigen Assay)

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Abbott HIVAG-1 Monoclonal	EIA	Serum / Plasma	Donor Screen & Neut. Kit	Abbott Laboratories Abbott Park, IL US License 0043	04/22/96
Coulter HIV-1 p24 Ag Assay; HIV-1 p24 Antigen ELISA Test System	EIA	Serum / Plasma	Donor Screen & Neut. Kit	Coulter Corporation Miami, FL US License 1185	03/14/96
Abbott HIVAG-1	EIA	Serum / Plasma	Prognosis & Neut. Kit	Abbott Laboratories	08/03/89
Abbott HIVAG-1 Monoclonal	EIA	Serum / Plasma	Prognosis & Neut. Kit	Abbott Laboratories	04/23/96
Coulter HIV-1 p24 Ag Assay; HIV-1 p24 Antigen ELISA Test System	EIA	Serum / Plasma	Prognosis & Neut. Kit	Coulter Corporation	03/14/96
Coulter HIV-1 p24 Ag Assay	EIA	Viral Culture Super-natant	Prognosis (Quantitative) & Neut. Kit	Coulter Corporation	03/14/96

Human Immunodeficiency Virus Type 1 (Anti-HIV-1 Assay)

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
HIVAB HIV-1 EIA	EIA	Serum / Plasma	Donor Screen	Abbott Laboratories Abbott Park, IL US License 0042	03/01/85
Recombigen (env & gag) HIV-1 EIA	EIA	Serum / Plasma	Donor Screen	Cambridge Biotech Corp. Rockville, MD US License 1062	05/01/90
Microsnk HIV-1 EIA (env & gag)	EIA	Serum / Plasma	Donor Screen	Cambridge Biotech Corp.	05/30/90
RLAV EIA	EIA	Serum / Plasma	Donor Screen	Genetic Systems Corp. Redmond, WA US License 0078	06/29/98
Murex SUDS HIV-1 Test	Rapid EIA	Serum / Plasma	Donor Screen	Murex Diagnostics, Inc. Norcross, GA US License 1152	05/22/92

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Vironostika HIV-1 Microelisa System	EIA	Serum / Plasma	Donor Screen	Organon Teknika Corp. Durham, NC US License 0956	12/18/87
UBI-OLYMPUS HIV-1 EIA	EIA	Serum / Plasma	Donor Screen	United Biomedical, Inc. Hauppauge, NY US License 1079	05/31/89
Novapath HIV-1 Immunoblot	WB	Serum / Plasma	Donor Supplemental	Bio-Rad Laboratories Hercules, CA US License 1109	06/15/90
HIV-1 Western Blot Kit	WB	Serum / Plasma	Donor Supplemental	Cambridge Biotech Corp.	01/03/91
EPIblot HIV-1	WB	Serum / Plasma	Donor Supplemental	Epitope, Inc. Beaverton, OR US License 1133	03/20/91
Fluorognost HIV-1 IFA	IFA	Serum / Plasma	Donor Supplemental	Waldheim Pharmazeutika G.m.b.H. Vienna, Austria US License 1150	02/05/92
HIVAB HIV-1 EIA	EIA	Dried Blood Spot	Non-Donor Screen	Abbott Laboratories	04/22/92
HIV-1 Urine EIA; Sensilyte Sentinel HIV-1 Urine EIA	EIA	Urine Screen	Non-Donor Screen	Calypte Biomedical Corp. Berkeley, CA US License 1207	08/06/96
RLAV EIA	EIA	Dried Blood Spot	Non-Donor Screen	Genetic Systems Corp.	06/29/98
Vironostika HIV-1 Microelisa System	EIA	Dried Blood Spot	Non-Donor Screen	Organon Teknika Corp.	04/11/90
Oral Fluid Vironostika HIV-1 Microelisa System	EIA	Oral Fluid	Non-Donor Screen	Organon Teknika Corp.	12/23/94
HIV-1 Western Blot Kit	WB	Dried Blood Spot	Non-Donor Supplemental	Cambridge Biotech Corp.	01/03/91
HIV-1 Western Blot Kit	WB	Urine	Non-Donor Supplemental	Cambridge Biotech Corp.	5/28/98
OraSure HIV-1 Western Blot Kit	WB	Oral Fluid	Non-Donor Supplemental	Epitope, Inc.	06/03/96
Fluorognost HIV-1 IFA	IFA	Dried Blood Spot	Non-Donor Supplemental	Waldheim Pharmazeutika G.m.b.H.	05/14/96

Human Immunodeficiency Virus Types 1 & 2 (Anti-HIV-1/2 Assay)

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Abbott HIVAB HIV-1/HIV-2 (rDNA) EIA	EIA	Serum / Plasma	Donor Screen	Abbott Laboratories Abbott Park, IL US License 0043	02/14/92
Genetic Systems HIV-1/HIV-2 Peptide EIA	EIA	Serum / Plasma	Donor Screen	Genetic Systems Corp. Redmond, WA US License 0978	08/22/97
UBI HIV-1/2 EIA	EIA	Serum / Plasma	Donor Screen	United Biomedical, Inc. Hauppauge, NY U.S. License 1079	12/20/96

Human Immunodeficiency Virus Type 2 (Anti-HIV-2 Assay)

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Genetic Systems HIV-2 EIA	EIA	Serum / Plasma	Donor Screen	Genetic Systems Corp. Redmond, WA US License 0978	04/25/90

Premarket Approvals -
Anti-HIV-1 Testing Service

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Home Access HIV-1 Test System	Dried Blood Spot Collection Device	Dried Blood Spot	Non-Donor Screen	Home Access Health Corp. Hoffman Estates, IL	07/22/96

Anti-HIV-1 Oral Specimen Collection Device

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Epitope OraSure HIV-1 Oral Specimen Collection Device	Oral Specimen Collection Device	Oral Fluid	For Use in Designated Non-Donor Screen and Non-Donor Supplemental Assays	Epitope, Inc. Beaverton, OR	05/09/91

HIV-1 Viral Load Assay

Tradename(s)	Format	Sample	Use	Manufacturer	Approval
Roche Amplicor HIV-1 Monitor Test	PCR	Serum / Plasma	Prognosis	Roche Molecular Systems, Inc. Branchburg Township, NJ	06/03/96

Regulation 4-2-10 Reporting Requirements for Multiple Employer Welfare Arrangements (MEWAs)

I. Authority

This regulation is promulgated under the authority of § 10-1-109, C.R.S.

II. Basis and Purpose

Many Multiple Employer Welfare Arrangements (MEWAs) have previously claimed ERISA preemption whereby health plans may operate without obtaining a license from the Division of Insurance. Section 10-3-903.5, C.R.S., regarding the Division's jurisdiction over providers of health care benefits was effective as of March 31, 1993. This statute as well as; recent advisory opinions from the US Department of Labor, has clarified the limited nature of the federal ERISA (Employee Retirement Income Security Act) preemption.

In addition, it has come to the Division's attention that producers who are licensed by the Colorado Division of Insurance have been involved in the sale of health plans offered by unlicensed entities. This regulation is intended to: (1) clarify the information to be filed under the provisions of § 10-3-903.5(7)(c), C.R.S. by MEWAs claiming exempt status from formal licensing requirements; (2) clarify the responsibilities of licensed producers, and; (3) to repeal and replace Insurance Regulation 4-2-10 (3 CCR 702-4, pg. 122).

III. Definitions

“Fully insured” means an arrangement where a licensed entity is liable to pay all health care benefits, less any contractual deductibles, coinsurance or copayments to be made by the enrollee. The liability of the licensed entity for payment of the covered services or benefits is directly to the individual employee, member or dependents) receiving the health care services or benefits. The contract issuance, claims payment and administration and all other insurance related functions remain the ultimate responsibility of the licensed entity.

“Health plan” is an arrangement such as a fund, trust, plan, program or other funding mechanism which provides health care benefits.

“Licensed entity” means a licensed insurance company; health maintenance organization; or nonprofit hospital, medical-surgical, and health service corporation having a certificate of authority to transact business in this state.

“Producer” means a licensed person as defined by Article 2 of Title 10.

“Substantial compliance” means that each benefit provided to an individual covered by a MEWA complies with the essential requirements of each mandated benefit.

IV. Filing Requirements of MEWAs

A filing under this regulation by a MEWA is solely for the purpose of providing the information required to the Commissioner in order to demonstrate if a MEWA complies with the requirements of § 10-3-903.5(c)(7), C.R.S. Determination of compliance or noncompliance will be provided in writing to the MEWA.

The following information is required to be filed in order to meet the filing requirements of § 10-3-903.5(7)(c), C.R.S. and for the Division of Insurance to make a determination regarding the qualification of a Multiple Employer Welfare Arrangement (MEWA) seeking exemption from licensure requirements.

A. Evidence that the MEWA has existed continuously since January 1, 1983. This is accomplished by submitting copies of formation documents, bylaws, if applicable, and financial reports, audited preferred, for years 1983, 1987 and 1991.

B. A copy of the sponsor association's organizational documents, membership criteria, ownership and a summary of the activities and benefits, other than health plan coverage, provided to its membership.

C. A copy of the most recent financial report, which includes at a minimum, a balance sheet, income statement, cash flow report and a detailed listing of assets, as of the MEWA's most recent fiscal year end. The financial report must disclose and support the required five percent (5%) unallocated reserve level.

D. The method of marketing and enrolling eligible participants.

E. Actuarial information that must be prepared by a qualified actuary as indicated by § 10-7- 114(1)(e), C.R.S. This information must include:

1. A copy of an opinion:

a) complying with the provisions of Colorado Insurance Regulation 3-1-8 (3 CCR 702- 3),

b) reflecting the adequacy of the health plan reserves and liabilities reflected in the financial report, and

c) reflecting the adequacy of the contribution and funding levels of the health plan.

2. A copy of the underlying actuarial report supporting such opinion, including all methods and assumptions employed.

F. A copy of the products offered along with a summary of benefits and a comparison of how each benefit is in substantial compliance with the state's mandated benefit provisions.

G. Such other relevant information as the Commissioner may request in order to evaluate the financial, actuarial and benefits of the health plan.

H. A copy of an audited annual financial report within 150 days of the MEWA's fiscal year end. Item's A and B above are only required to be filed once, unless materially altered. Items C through G will be required to be filed annually within sixty (60) days following the fiscal year end of the MEWA. Item H shall be filed annually as indicated.

V. Authorized Insurance Arrangements

Qualifying health plans that are not subject to licensure as an insurer under Colorado law are plans which are:

A. Fully insured;

B. Established and maintained by a single employer;

C. Established and subject to a collectively bargained agreement pursuant to § 10-3-903.5-(7)(b)(II), C.R.S.;

D. Established by a government entity, pursuant to § 10-3-903.5(b)(I), C.R.S.; or

E. Determined to be in compliance with § 10-3-905.3(7)(c), C.R.S. and Section IV of this regulation.

Pursuant to Colorado law, health plans sold to residents of Colorado are subject to Colorado law even if the master policy is issued and delivered outside of Colorado.

VI. Producer Responsibilities

No producer may solicit, advertise, market, accept an application, or place coverage for a person who resides in this state with a MEWA unless the producer first verifies that the MEWA complies with the requirements of this regulation and the provisions of § 10-3-903.5, C.R.S. This is accomplished by the producer acquiring a copy of the Division's correspondence determining that the MEWA is in compliance with this regulation and the provisions of § 10-3- 903.5(7)(c), C.R.S.

Lack of knowledge regarding the compliance of any organization or health plan is not a defense to a violation of this regulation. Any producer involved in the solicitation or sale of health plans through unauthorized insurers or MEWAs which are found not to be in compliance with the provisions of § 10-3-903.5, C.R.S. and this regulation are subject to discipline or action including fines, suspension or revocation of their license.

VII. Enforcement

In the event that a MEWA ceases to qualify under Section V of this regulation, it will be transacting the business of insurance in the State of Colorado without a license and subject to the procedures of Parts 9 and 10 of Article 3 of Title 10, C.R.S. and the provisions of the State Administrative Procedure Act, Part 4 of Title 24, C.R.S. as applicable. Any insurer that may have issued a contract to a health plan is not exempt from the liability under its contract solely due to the unauthorized status of a health plan.

VIII. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

IX. Effective Date

This regulation shall be effective July 1, 1994.

Amended Regulation 4-2-11 RATE FILING AND ANNUAL REPORT SUBMISSIONS HEALTH INSURANCE

Section 1 Authority

This regulation is promulgated pursuant to the authority of § § 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), and 10-16-109, C.R.S.

Section 2 Background and Purpose

The purpose of this regulation is to ensure that health insurance rates are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings and to require an annual rate report. This regulation provides a listing of the items required to be included in this Annual Rate Report.

Section 3 Applicability and Scope

This regulation applies to all companies operating in the State of Colorado, as defined in Section 4. This regulation concerns all health insurance rate filings, including, but not limited to, comprehensive health insurance, long term care, supplemental health, limited benefit health, prepaid dental, limited service licensed provider networks, disability, and Health Maintenance Organization (HMO) coverages.

Section 4 Definitions

A. “Anticipated” or “Targeted Loss Ratio” means, for purposes of this regulation, the ratio of expected benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over this same period. The anticipated loss ratio should be calculated on an incurred basis as the ratio of incurred losses to earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefit or loss ratio calculations must be displayed without the inclusion of active life reserves.

B. “Company” means, for purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to, licensed property and casualty insurance companies; licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; HMOs; prepaid dental companies; and limited service licensed provider networks.

C. “Filing Date” means, for purposes of this regulation, the date that the rate filing is received at the Division of Insurance.

D. “Excessive Rates” means, for purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the benefits provided.

E. “Inadequate Rates” means, for purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace.

F. “Indemnity Benefits” means, for the purpose of the twenty percent (20%) limitation imposed on HMOs, the following benefits: out-of-area services, supplemental benefits (such as vision and dental provided on a non-contractual fee-for-service basis) and point-of-service benefits. It does not include any benefits provided by an HMO for which there exists a hold harmless agreement between the providers and the HMO.

G. “On-Rate-Level Premium” is the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

H. “Pod” means any subdivision or subgrouping of a network, if arrangements between the plan and participating providers or the policy itself have specific incentives for the use of providers and services within the subdivision or subgrouping of the network.

I. "Premium" means, for purposes of this regulation, the amount of money paid by the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier’s expectation of the insured’s future claim costs and the insured’s share of the carrier’s claims settlement, operational and administrative expenses, and the carrier’s cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

J. "Prior Approval" is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collection of premium, advertising, or any other use of the rate.

K. “Qualified Actuary” is a person who meets the qualifications in Regulation 1-1-1.

L. “Rate” means, for purpose of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier’s expectation of the insured’s future claim costs, and the insured’s share of the carrier’s claim settlement, operational and administrative expenses, and cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

M. “Rate Filing” means, for purposes of this regulation, is a filing that contains all of the items required in this regulation and the bulletin entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers” , and 1) for individual products, the proposed base rates and all rating factors, the underlying rating assumptions, and support for changes in these rates, factors and assumptions; and 2) for group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

N. “Retention” means, for the purposes of this regulation, the percentage of total premium determined by either 100% minus the percentage of total premium anticipated to be paid for policyholder benefits or 100% minus the anticipated loss ratio.

O. “Trend” or “Trending” means any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.

P. “Use of Rates” means, for purposes of this regulation, the date that the rates are: 1) distributed to agents or made available to others outside the company; or 2) quoted to any party outside the company.

Q. “Unfairly Discriminatory Rates” means, for purposes of this regulation, charging different rates, for the same benefits provided, to individuals, or groups, with like expectations of loss. For individual policies, rates which differ for new and renewal policies are not necessarily considered unfairly discriminatory. In addition, a rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

Section 5 General Rate Filing Requirements

Failure to supply the information required in Sections 5, 6 and 7 of this Regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content . All filings that are not returned on or before the 15th business day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing company on or before the 30 th business day after receipt. Correction of any deficiency, including deficiencies identified after the 30th business day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this Regulation shall render a rate filing subject to prior approval by the Division of Insurance that is not otherwise subject to prior approval as provided by statute.

A. General Requirements

1. Required Submissions:

a. All companies must submit rate filings whenever the rates charged new or renewal policyholders or certificateholders differ from the rates on file with the Division of Insurance. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in the trend or other rating assumptions. A company may file changes to the base rates or the index rate, for small group rate filings, due solely to trend for a maximum of one year. The continued use of a trend or any other continuing assumption is required to be verified at least annually for continued appropriateness.

b. A separate rate filing is required for each major line of business. Rate filings should not be combined with form filings. Each type requires a separate filing.

c. Where a company complies with the loss ratio guarantee requirements of § 10-16-

107(1.5), C.R.S., the rate will not be considered excessive. However, such rates are still subject to the statutory requirement that rates shall not be inadequate or unfairly discriminatory, and are subject to review by the Commissioner on these grounds. Companies filing loss ratio guarantees are therefore subject to this regulation in all respects.

2. Timing and Submission: Unless a filing is specifically identified as requiring prior approval (e.g. Medicare supplemental), all filings are classified as "file and use." "File and use" requires the company to file the rates and rating data with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates except as provided for in Section 7(C) of this regulation for large group contracts. If a rate change has been implemented without being filed with the Division of Insurance, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits. All filings must be filed with the Rates and Forms Section of the Division of Insurance.

3. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer or returned by the Division of Insurance as incomplete or disapproved as unjustified, and subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, the rates may not be used or distributed. Nothing in this Regulation shall render a rate filing subject to prior approval by the Division of Insurance that is not otherwise subject to prior approval as provided by statute.

4. Duplicates and Return Postage: All filings must be submitted in duplicate, and include an envelope, with sufficient prepaid postage, large enough to contain one complete set of the material. These filings must be collated so that each copy of the filing contains all required documents. If the company fails to comply with these requirements, the company will be notified that the filing has been returned as incomplete. If a filing is returned due to lack of completeness, the rates may not be used or distributed.

5. Company Specific: A separate filing must be submitted for each company. A single filing, which is made for more than one company or for a group of companies, is not permitted. This applies even if a product is comprised of components from more than one company, such as an HMO/indemnity point-of-service plan.

6. Required Inclusions: The level of detail and the degree of consistency incorporated in the experience records of the company are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid company experience should be used whenever possible. This information may include the company's experience and judgment; the experience or data of other companies or organizations relied on by the company; the interpretation of any statistical data relied on by the company; descriptions of methods used in making the rates; and any other similar information. In addition, the Commissioner may request additional information necessary to adequately support the rate change request.

B. Forms and Actuarial Certification

1. Required Forms: A fully completed Filing Transmittal Form and Form HR-1 must be completed for each rate filing. These forms are available in the Division of Insurance bulletin entitled "Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers" . This Bulletin may be found on the Division of Insurance's website, www.dora.state.co.us/insurance/.

2. Actuarial Certification: A signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly

discriminatory. (The requirements for the actuarial certification for Medicare Supplement rate filings may be found in Section 14(H) of Colorado Insurance Regulation 4-3-1.)

Section 6 Actuarial Memorandum

The rate filing must contain an actuarial memorandum, either signed by, or prepared under the supervision of, a qualified actuary, containing, at a minimum, the following sections:

A. Summary: A brief written summary of the reason for the rate filing, the marketing method(s), and the premium classifications and product descriptions. In addition, the summary must state whether the premiums will be charged on an issue age, attained age, renewal age or other basis.

B. Rating Period: The memorandum must identify the period for which the rates will be effective. If the rating period is not clearly identified, it will be assumed to be for twelve months.

C. Underwriting: The memorandum must include a brief description of the extent to which this product will be underwritten, if a new product, or the changes, if any, to the underwriting standards, if an existing product . The memorandum should include the expected impact on the claim costs by duration and in total. The company shall state separately the effects of different types of underwriting: medical, financial or other. An example of an acceptable brief description is: "This policy form is subject to limited underwriting with yes/no questions. The expected impact is: duration 1 = .15; duration 2 = .05; duration 3 = .03 decrease in claim costs."

D. Effect of Law Changes: The memorandum should identify and quantify any changes to the rates, expenses, and/or medical costs that result from changes in law(s) or regulation(s). This quantification must include the effect of specific mandated benefits and anticipated changes.

E. Rate History: The memorandum must include a chart showing the rate changes implemented in at least the three years immediately prior to the date of the filing. The cumulative effect of all rate filings, submitted in the prior year, on renewal rates should be specified, including the range of increases the renewing policyholder may experience, i.e., the minimum, average, and maximum.

F. Coordination of Benefits: Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

G. Relation of Benefits to Premium: The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums. This relationship will be presumed to be reasonable if the company complies with any one of the following methods:

1. Use of the minimum required loss ratio: Colorado statutes require minimum acceptable loss ratios for Medicare supplement and long- term care products only. These loss ratio requirements, and other rating requirements, can be found in Colorado Insurance Regulations 4-3-1 and 4-4-1. The minimum required loss ratios will be evaluated in conjunction with the expected loss ratios as part of the determination of the acceptability of a rate change request.

2. The product is priced using one of the following methods. Please note that these relationships are considered “safe harbor” relationships. Rates may be alternatively justified using part 3 of this Subsection.

    a. For individual products issued to HIPAA eligible individuals, if the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.

    b. For conversion products, if the anticipated loss ratio is at least 125%.

c. For the following types of business, if the company prices the product at or above any of the following minimum anticipated loss ratios.

Comprehensive Major Medical (Individual)	65%
Comprehensive Major Medical (Small Group)	70%
Comprehensive Major Medical (Large Group)	75%
Specified or Dread Disease	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%

3. Justification of the Retention Percentage: The Actuarial Memorandum for all other rate filings must list and adequately support each component of the retention percentage (1 – the loss ratio). These components should sum to the total company retention percentage. The memorandum must clearly describe the amount of the fixed and/or variable expense provision and how this provision is to be accounted for in the final rate. The memorandum must include either a statement that the expense provision has been adjusted to appropriately reflect Colorado requirements and reflects the operating methods of the company and any Colorado-specific anticipated expenses, or a statement indicating that this provision reflects an average of expenses in all markets in which the company conducts its business. However, if the company qualifies as a home or regional home office under Colorado Insurance Regulation 2-1-2 and §10-3-209 (1)(b)(I)(B), C.R.S., the expense provision must accurately reflect all Colorado-specific expenses .

4. Lifetime Loss Ratio: If the rate change request is based on a lifetime loss ratio, the filing should identify the loss ratio and how the loss ratio for the projection period was determined. Supporting data should be provided on a calendar year basis . If credible data is not available, the filing must identify and justify the use of appropriate collateral data.

H. Provision for Profit and Contingencies: The memorandum must identify the amount or percentage of the provision for profit and contingencies, and how this provision is included in the final rate. If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process.

I. Complete Description of the Calculation of the Increase: The memorandum must contain a section with a complete description as to how the requested increase was calculated, including all underlying rating assumptions, with detailed support for each assumption . This description may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but must completely describe how the increase was determined. The memorandum must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

J. Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. The trend assumptions shall be, if practical, separately quantified into two categories, medical and

insurance, as defined below:

1. Medical trend is the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

2. Insurance trend is the combined effect of underwriting wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

K. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims a year (both standards must be met within a maximum of three years), if the rate change is related to claims experience. The memorandum must discuss the credibility of the Colorado data with the requested rate change based upon as much Colorado data as possible . The memorandum must also identify and discuss the source, applicability and use of collateral data used to support partially credible Colorado data. The memorandum should also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rate change request was modified for the partially credible data.

L. Data Requirements: The memorandum must, at a minimum, include earned premium and loss experience data, submitted on a Colorado-only basis for at least 3 years, if available, and on a national, regional or other appropriate basis, if the Colorado data is not fully credible, or provide an acceptable reason(s) as to why this data was not provided. Rate changes must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. If the Colorado experience is not fully credible, the data may be supplemented with national data, or other relevant data. The filing should clearly discuss the reliance upon non-Colorado data, and the credibility of the Colorado data. The experience period must include consecutive data no older than six months prior to the date of the filing, or a clear and acceptable reason as to why such data was not included. The loss data must be on an incurred basis, including both the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments.

M. Side-by-Side Comparison: Each memorandum must include a “side-by-side comparison” identifying the proposed change(s). This comparison should include three columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum must specifically so state.

N. Loss Ratio Projections: The memorandum must contain a section projecting the loss ratio, over the rating period, both with and without the requested rate change. For long tail lines, such as long term care and long term disability, the projections should include a timeframe as to when the target loss ratio will be achieved.

O. Other Factors: The memorandum must clearly display all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for changes to any of these factors.

Section 7 Additional Rate Filing Requirement by Line of Business

The following subsections set forth the requirements by separate lines of business, which must be complied with in addition to the above general requirements:

A. Individual: Renewal rates for individual health insurance plans may not be affected by the health status or claims experience of the individual insured. A "claims experience factor," or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited. Group policies issued to valid multi-state associations, meeting the requirements of § 10-16-214 (2), CRS, will be considered individual policies for rating purposes only .

B. Small Group Major Medical: The provisions of § § 10-16-105 and 10-16-107, C.R.S., and Colorado Insurance Regulations 4-6-5, 4-6-7, and 4-6-8, shall apply to the filing of rates for small employer health benefit plans. The factors usually included in the determination of a trend percentage are not considered a small group rating variable and must be included in the calculation of the index rate. A company may, in a single rate submission, file up to a maximum of twelve different index rates for effective dates in the subsequent twelve-month period; however, only one index rate can be effective at any given time. Only the factors defined in Regulation 4-6-7 may be used to adjust the filed index rate, and changes should be clearly set forth in the side-by-side comparison. Each rate filing should contain all tables necessary to recalculate the small group renewal rates, even if the factors in the table have not changed. It should be clearly indicated that the factors in these tables are unchanged.

C. Large Group Major Medical: Large group major medical health care coverage contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. A company may issue rate quotes using the rating factors contained in the filing concurrent with the submission of the filing to the Division of Insurance. While the final rate charged the large group may differ from the initial quote, all rating variables must be on file with the Division of Insurance.

   Although it is not necessary to submit a separate rate filing for each large group policy issued, each company must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division of Insurance. The company shall make all such information available for review by the Commissioner upon request. All such requests will be made at least three (3) business days prior to the date of review.

D. Medicare Supplemental: A Medicare supplemental insurance policy is defined in § 10-18-101(4), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-3-1 and § § 10-18-101 to 109, C.R.S. If the requirements of both Regulation 4-3-1 and this Regulation are not met, the filing will be considered incomplete and returned to the company. Medicare supplemental filings require prior approval. (The requirements for the actuarial certification for Medicare Supplement rate filings may be found in Section 14(H) of Regulation 4-3-1.) Rating requirements may be found in Sections 10(E)(2), 13 and 14(G) – (J).

E. Long Term Care: Long Term Care insurance is defined in § 10-19-103(5), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-4-1 and § § 10-19-101 to 115, C.R.S. If the requirements of both Regulation 4-4-1 and this regulation are not met, the filing will be considered incomplete and returned to the company. The filing must also:

1. Demonstrate that investment income has been considered in the development of the rate;

2. provide the expected loss ratios for both the experience period and the projection period;

3. provide the ratio of the actual loss ratio to the expected loss ratio for each year of the life of the policy on both a durational and calendar year basis; and

4. provide a discussion as to how the original pricing assumptions have changed historically, and how the assumptions for the future period compare to the original pricing assumptions and the current rating assumptions.

F. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate.

G. Health Maintenance Organization (HMO): The rates for all HMO point-of-service (POS) benefits must be separately determined and supported. The Actuarial Memorandum supporting any rate filing for a policy which includes POS or other indemnity benefits must include a statement that all indemnity benefits are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred. HMOs that exceed the 20% limitation in the prior calendar year may be prohibited from offering a point-of-service plan for new issues until compliance can be demonstrated.

H. Limited Service Licensed Provider Network (LSLPN): Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost-plus or retrospective rating basis.

Section 8 Annual Rate Report

All foreign companies (whose reported Colorado health insurance written premiums were in excess of $20,000,000 in the preceding calendar year) and all Colorado domestic companies (without regard to yearly earned premium), subject to this regulation, must file an annual report as described in this section, with the following exceptions:

- Companies writing only disability income policies;

- Companies whose only in-force health policies are non-cancelable policies, if the premiums cannot be increased; and

- LSLPNs who contract exclusively with national, state or local governments and whose rate, premium or reimbursement rate is determined by the contracting governmental entity.

All other companies, subject to this regulation, may be required to file this Annual Report upon request from the Division of Insurance. This report must comply with the following requirements:

A. Timing and Submission: The Division of Insurance must receive all annual reports on or before June 1 of each year. Failure to file this report by June 1 will result in a late penalty not to exceed $100 per day. Reports not discussing each of the required items from Part B of this Subsection, completely, may be subject to a fine for an incomplete report.

B. Scope and Certification: the report should be organized by major line of business. For the purposes of this requirement, a “major line of business” includes at least the following categories: individual, small group, large group, Medicare risk, and Medicaid risk. For each of the company’s major lines of business, the report should discuss the following topics:

1. Reason for filing: The report must provide the reason for filing the report. Acceptable

reasons include 1) the company is a Colorado domestic company, and 2) the company is a foreign company with over $20 million in written Colorado health insurance premium during the prior calendar year. If the report is being prepared by a foreign company, the total amount of written Colorado health insurance premium during the prior year should be included as part of the reason for filing.

2. Business written: The report should contain a brief description of each of the major lines of business written or inforce during the prior calendar year.

3. Rate filings filed: The report must list by date and major line of business a brief description of all rate filings filed with the Division of Insurance during the prior calendar year.

4. Certification: The report must be signed by a qualified actuary. For each major lines of business, including those for which a filing has not been made in the prior calendar year, the report must include a certification which states that the current rate(s) or premium for such line(s) of business are not excessive, inadequate or unfairly discriminatory. For HMOs, the qualified actuary must also certify that the indemnity benefits provided did not exceed 20% of the net medical and hospital benefits provided during the prior calendar year. Long term care insurance for which the company can issue a certification as set forth in Subsection 8(D)(4) of this regulation is exempt from this requirement.

5. Automatic factors: The report must specifically: 1) list all automatic rating factors in use, including trend and inflation; 2) describe how each of these factors were determined; 3) provide support for the continued use of these factors; and 3) state that, in the actuary's opinion, the continued use of any such factors used in calculation of the rates is still appropriate.

6. Appropriateness of rates charged: The report must include a brief analysis of the appropriateness of rates charged to Colorado policyholders or certificate holders in the prior calendar year for each major line of business. This analysis should include a table containing the earned premium, incurred losses, and number of policyholders for each major line of business. This analysis shall compare the anticipated to actual results for the prior calendar year by comparing the actual to expected loss ratios and any other information as deemed appropriate for this analysis.

7. Reinsurance arrangements: The report must include a discussion of the reinsurance arrangements in place and the reasonableness of these arrangements as regards the protection against claims volatility these arrangements provide the company.

8. Future rate changes planned: The report must describe the steps, if any, taken or proposed to be taken, for each major line of business, to adjust the current year or future rates due to these findings. If a company states in this report that an indicated increase will not be implemented in the following year, nothing in this regulation shall be construed to prohibit the company from implementing a supportable rate increase in future years.

C. The Division of Insurance has determined that the information contained in these reports may be considered confidential pursuant to § 24-72-204, C.R.S., and/or § 10-16-107(3)(e)(II), C.R. S. If a carrier desires confidential treatment of this "Annual Rate Report" , a Vaughn Index must be completed. Please see the bulletin entitled, "Guidelines for Rate, Rule, Loss Cost and Form Filings Containing Confidential Information" . This Bulletin may be found on the Division of Insurance's website, www. dora.state.co.us/insurance/. It should be noted that HMOs are not afforded automatic confidential treatment in the filing of this report and must also complete a Vaughn Index.

D. Additional Information: In addition to the above, the report for companies writing certain categories of

business must include the following information:

1. Health Maintenance Organizations:

    a. Non-Developed Rates: If the HMO accepts business on a risk basis and does not develop rates (common for Medicaid and some Medicare business), the actuary should include:

        (i) A separate certification that the premium or reimbursements received for such business are sufficient to satisfy all medical expenditures, guaranteed provider benefits, internal and external expenses associated with the business, and all other costs associated with the risk transfer, or a quantification as to the amount of any deficiency; and

        (ii) A description of any changes to the plan, provider risk arrangements or any other material aspect of the benefits provided under these plans.

    b. Provider Compensation: The manner in which the providers are compensated has a material effect on the rating process. In the report, therefore, the actuary should provide all of the following:

        (i) Clearly describe the type and scope of capitated or other provider risk sharing arrangements (if material to the rating assumptions), including the existence of any multiple capitation contracts, and any other material aspect of the benefits provided.

        (ii) State the degree to which the actuary has evaluated the financial position of the risk-assuming provider entities and the results of that evaluation.

        (iii) State whether or not the rates include an adequate provision for contractual incentive payments.

        (iv) For all provider agreements which materially impact the rating assumptions, note whether or not the payments to these providers assumed in the rate development have, in fact, been confirmed by an executed agreement. For example, if the rates assume that all primary care will be performed by physicians who will be paid a fixed per member per month capitation in compensation for their services, the actuary should note whether or not the contract between the HMO and the physician group which agrees to this rate of compensation has been executed and will be in effect for the period the rates are effective. If the actuary is not aware or cannot determine if the amounts of provider compensation assumed in the rates is supported by actual, executed contracts, the actuary should still identify these assumptions and note that there is no confirmation that the supporting contracts have been executed.

        (v) Indicate the impact the above arrangements/findings have on the rates.

    c. Pods: If the HMO uses pod ratings or classifications, the actuary should adequately support the rate differentials through use of historical loss/expense experience and prospective provider compensation arrangements.

    d. Prospective Changes: The report should include a description of any other current and anticipated changes that would affect the HMO's financial solvency, organizational structure, or market share.

e. Indemnity Benefits. The filing must demonstrate that indemnity benefits do not exceed twenty percent of net medical and hospital expenses incurred during the previous calendar year.

2. Small Groups: Pursuant to § 10-16-105(6.5), C.R.S., all companies who sell or offer for sale policies subject to the requirements of this regulation shall submit an annual actuarial rate certification to the Division of Insurance on or before March 1 of each calendar year. The small group certification, required under § 10-16-105 (6.5), C.R.S., may be included in this annual report provided the company submits written notification to the Division of Insurance on or before March 1, and clearly indicates, in the annual filing, that the annual filing satisfies the annual filing requirements in this section and the small group certification requirements in § 10-16-105 (6.5), C.R.S. The certification must be signed by a qualified actuary and must contain at least the following:

   a. The name of the company and the identification number assigned by the National Association of Insurance Commissioners;

   b. A list of all plans of health benefits and policy forms to which the certification applies;

   c. A statement that covers at least the points listed in the following illustration:

      "I am familiar with the small group rating laws and regulations of the state of Colorado . In my opinion, as of January 1 of the year of this certification, the premium rates and rating methodology to which this certification applies are not excessive, inadequate or unfairly discriminatory," and

   d. The name and title of the qualified actuary signing the certification and the name of the firm with which the actuary is associated.

3. Limited Service Licensed Provider Networks (LSLPN): The annual certification must certify as to the appropriateness of the charges or rates and shall accompany the annual rate filing along with adequate supporting information. This certification must state that the rates are not excessive, inadequate or unfairly discriminatory.

   For all provider agreements which materially impact the rating assumptions, the report must note whether or not the payments to these providers assumed in the rate development have in fact been confirmed by an executed agreement. For example, if the rates assume that all services will be performed by providers who will be paid a fixed PMPM capitation in compensation for their services, then the actuary should note whether or not the contract between the LSLPN and the provider group which agrees to this amount of compensation has been executed, and will be in effect for the period the rates are effective. If the actuary is not aware or cannot determine if the amount of provider compensation assumed in the rates is supported by actual, executed contracts, then the actuary should still identify these assumptions and note that there is no confirmation that the supporting contracts have been executed.

   Non-Developed Rates: If the LSLPN accepts business on a risk basis and does not develop the rates (common for Medicaid business), then the actuary should include a:

   a. Separate certification that the premium or reimbursements received for such business will be sufficient to satisfy all medical expenditures, guaranteed provider benefits, internal and external expenses associated with the business, and all other costs associated with the risk transfer, or a quantification as to the amount of any deficiency, and a

b. Description of any changes to the plan, provider risk arrangements or any other material aspect of the benefits provided under these plans.

The report should state the degree to which the actuary has evaluated the financial position of the risk assuming provider entities, the results of that evaluation, and whether or not the rates include an adequate provision for contractual incentive payments.

4. Long Term Care Insurance: The annual report must include a statement as to whether or not the actuary expects premiums to be level over the life of the policy. In lieu of the requirements of Subsections (8)(A) and (B) of this regulation, the actuary may certify that the premiums have remained level for existing policyholders and are expected to remain level over the life of the policy.

E. Prohibited Rating Practices

The Division of Insurance has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with § § 10-16-107, 10-16-109, and 10-3-1110(1), C.R.S., the following are prohibited:

1. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating; and

2. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income, unless such factors are adequately supported by acceptable data.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 10 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of certificates of authority. Among others the penalties provided for in § 10- 3-1108, C.R.S. may be applied.

Section 11 Effective date

This regulation is effective for all rate filings submitted to the Colorado Division of Insurance on or after December 1, 2005.

Section 12 History

Regulation 4-2-11, effective November 1, 1992.

Regulation Repealed and Re-promulgated, effective February 1, 1999.

Regulation amended for rate filings submitted on or after January 1, 2001.

Regulation amended for rate filings submitted on or after December 1, 2005 .

Regulation 4-2-13 Mammography Minimum Benefit Level

I. Authority

This regulation is promulgated under the authority of § 10-1-109 C.R.S.

II. Basis and Purpose

The purpose of this regulation is to provide a method for adjusting the minimum mammography benefit which reflects increases and decreases in the consumer price index, as provided in § 10-16-104(4)(a), C.R.S.

III. Rule

As of September 1, 1995, the minimum mammography benefit will be $55.37.

Hereafter, on September 1 of each year, every individual and group sickness and accident insurer, non-profit hospital, health service corporation and health maintenance organization subject to § 10-16-104(4)(a) and 10-3-903(2)(h) C.R.S. shall annually update its mammography benefit to reflect the most recent annual national Consumer Price Index - Urban (CPI-U) published by the U.S. Bureau of Labor and Statistics. This may be done by either revising the policy forms or evidence of coverage, processing claims at the new benefit level or both.

IV. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

V. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision shall not be affected thereby.

VI. Effective Date

This regulation will be effective September 1, 1995.

Regulation 4-2-15 Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers

I. Authority

This regulation is promulgated pursuant to Sections 10-1-109 and 10-16-121(5), Colorado Revised Statutes (C.R.S.).

II. Purpose

The purpose of this regulation is to describe the entities subject to the provisions of Section 10-16-121, C.R.S., which concerns required provisions in insurance carriers' contracts with health care providers,

and to establish, how those entities shall meet the requirements of Section 10-16-121, C.R.S.

III. Applicability and Scope

The provisions of this regulation shall apply to all contracts that concern the delivery, provision, payment or offering of care or services covered by a managed care plan that are entered into between a carrier and a provider or its representative, or between a carrier and an intermediary.

IV. Clarification of Terms

A. "Carrier is defined in Section 10-16-102(8), C.R.S. An entity providing a "health coverage plan" (defined in Section 10-16-102(22.5) that is subject to the insurance laws and regulations of Colorado comes under the definition of a carrier. Examples of carriers include, but are not limited to, sickness and accident insurers, nonprofit hospital, medical-surgical, and health service corporations, health maintenance organizations, limited service licensed provider networks, prepaid dental care plan organizations and if they provide health benefits, private passenger automobile insurance carriers, workers' compensation carriers, and disability carriers.

B. "Intermediary" is defined in Section 10-16-102(25.5), C.R.S. An intermediary must be authorized by health care providers to negotiate and execute provider contracts with carriers on behalf of such, providers. Examples of intermediaries may include but are not limited to: medical service organizations, provider networks, provider organizations, physician group practices, and physician hospital organizations.

C. "Managed care plan" is defined in Section 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: preferred provider plans, gatekeeper plans, health maintenance organization plans, plans offered by limited service licensed provider networks, prepaid dental plans, and plans that provide different levels of benefits or claims payments depending on whether a covered person uses specified providers (sometimes called in-network providers).

V. Rules

I. Each and every contract between a carrier that has covered lives in Colorado and a provider or its representative that concerns the delivery, provision, payment, or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended after January 1, 1997, shall contain provisions substantially similar to the following:

A. "No individual or group of providers covered by this contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of [name of carrier] or an entity representing or working for the carrier (e.g., a utilization review company)."

B. "[Name of carrier] or an entity representing or working for the carrier shall not to; prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual or group or providers covered by this contract."

C. "[Name of carrier] shall not terminate this contract because a provider covered by this contract expresses disagreement with a decision by [name of carrier] or an entity representing or working for such carrier to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision, or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients."

II. Each and every contract between a carrier and an intermediary that concerns the delivery, provision, payment, or offering of care or services covered by a managed care plan that is issued, renewed, amended or extended after January 1, 1997, shall contain a provision substantially similar to the following:

"[Name of intermediary] shall include in each and every one of its underlying contract'; authorizing said intermediary to negotiate and execute contracts with carriers on behalf of providers a provision substantially similar to the following:

> Each and every contract which [name of intermediary] negotiates and executes with carriers, on behalf of the providers covered by this intermediary-provider contract, shall contain a provision stating that: 1) No individual or group of providers covered by the contract shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or an entity representing or working for such carrier (e.g., a utilization review company); 2) The carrier or an entity representing or working for such carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of a individual or group of providers covered by the contract; and 3) The carrier shall not terminate any contract executed by [name of intermediary] because any individual or group of providers covered by the contract (a) expresses disagreement with a decision by the carrier or an entity representing or working for such carrier to deny or limit benefits to a covered person, or (b) assists the covered person to seek reconsideration of the carrier's decision, or (c) discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients."

VI. Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

VII. Effective Date

This regulation is effective on October 30, 1996.

Amended Regulation 4-2-16 Women's Access To Obstetricians, Gynecologists And Certified Nurse Midwives Under Managed Care Plans

Table of Contents

Section 8 Effective Date

Section 9 History

Section 1 Authority

This regulation is promulgated pursuant to Section 10-1-109 and 10-16-107(5)(b), C.R.S.

Section 2. Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Section 10-16-107(5), C.R.S., concerning women's access to obstetricians, gynecologists, and certified nurse midwives in managed care plans.

Section 3. Applicability And Scope

The provisions of this regulation shall apply to all managed care plans that provide coverage far reproductive health or gynecological care. “Managed care plan” is defined in Section 10-16-102(26.5), C.R.S. Examples of managed care plans include but are not limited to: preferred provider plans, gatekeeper plans, health maintenance organization plans, plans offered by limited service licensed provider networks, and plans that provide better coverage (e.g., pay a greater percentage of covered expenses or have lower copayment requirements) if a covered person uses specified providers (sometimes called participating or in-network providers).

Section 4. Definitions

A. “Reproductive health and gynecological care” means care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy and childbirth, and related preventive care.

Section 5. Rules

A. A managed care plan that provides coverage for reproductive health or gynecological care shall not be issued or renewed unless such plan either provides a woman covered under the plan direct access to an obstetrician, gynecologist, or certified nurse midwife, participating and available under the plan, for her reproductive or gynecological care or has referral procedures in place that comply with this regulation.

B. A managed care plan will be considered to have provided “direct access” to an obstetrician, gynecologist, or certified nurse midwife for reproductive and gynecological care only if a woman covered under the plan has the option of selecting a participating obstetrician, gynecologist or certified nurse midwife who is available under the plan as her primary care provider, or :

1. Can herself directly make an appointment with an obstetrician, gynecologist or certified nurse midwife who is participating and available under the plan;

2. Is not required as a condition of coverage to get prior approval or a referral from her primary care provider, the managed care plan, a representative of the managed care plan, or any other entity for an appointment/visit with an obstetrician, gynecologist or certified nurse midwife who is participating and available under the plan; and

3. Is not required to pay more out-of-pocket for directly accessing an obstetrician, gynecologist, or certified nurse midwife who is participating and available under the plan than if she received prior approval for, or a primary care provider referral to, such an obstetrician, gynecologist or certified nurse midwife.

C. A managed care plan that does not provide direct access pursuant to subsection B shall have procedures in place to ensure that a woman covered under the plan who requests a referral to, or preauthorization of care provided by, an obstetrician, gynecologist or certified nurse midwife participating and available under the plan for her reproductive and gynecological care shall not have such referral or preauthorization unreasonably withheld. Such procedures shall be in writing, shall be provided upon request and at no charge to the Division of Insurance, a covered person, or a participating provider, and shall make provision for the following:

1. A request for a referral or preauthorization may be made orally (e.g., by telephone) or in writing, at the discretion of the covered woman making the request The managed care plan's procedures shall specify whether the request should be submitted to the plan or to the primary care provider, or whether either may receive the request.

2. A managed care plan may require that a request by a woman for a referral to, or preauthorization of care provided by, a participating obstetrician, gynecologist or certified nurse midwife include the following information only:

    a. The reason for the request for referral or preauthorization of care and the type of care being sought (e.g., ongoing gynecological care, prenatal care, etc.), including sufficient information to determine if referral services requested are a benefit under the plan;

    b. The number of visits or period for which the referral or preauthorization is being requested (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

    c. Identifying information (e.g., name of primary care provider, name of the obstetrician, gynecologist or certified nurse midwife to whom the woman wants a referral, plan number, enrollee name, etc.).

3. A request for a referral or preauthorization shall be approved or denied within three (3) working days of the date on which the request was made if it is an oral request, or within three (3) working days of the date on which it was received if it is a written request Where a plan allows a primary care provider to process referral requests, pursuant to Section V.C.1, of this regulation, the same timelines shall apply.

4. An approval of a request by a woman for a referral to, or preauthorization of care provided by, a participating obstetrician, gynecologist or certified nurse midwife shall include, at minimum, the following information:

    a. The number of visits or period for which the referral or preauthorization is being approved (e.g., for one visit, for all obstetrical care throughout the term of a pregnancy, etc.); and

    b. The plan's understanding of the reason for the referral (e.g., ongoing gynecological care, prenatal care, etc.).

5. Approvals and denials of requests may be made orally but all denials shall be followed up by the health coverage plan or its representative within three (3) working days of the receipt of the original oral or written request with a detailed written explanation of the reason (s) for the denial, The written denial shall also describe the process by which the covered person may appeal and/or file a grievance concerning the denial pursuant to Division of Insurance Regulation 4-2-17.

6. Managed care plans shall not financially penalize, sanction, terminate, or reward a

participating provider responsible for making referrals based on the volume and/or consequent expenditures incurred as a result of that provider's referrals to participating obstetricians, gynecologists, or certified nurse midwives made pursuant to this regulation.

7. A managed care plan or its representative shall not deny a request for a referral to, or preauthorization of care by, a participating obstetrician, gynecologist, or certified nurse midwife solely because a covered woman's primary care provider is able/qualified to provide the same reproductive health or gynecological care, treatment or diagnostic tests as the obstetrician or gynecologist.

8. Managed care plans may require an obstetrician, gynecologist, or certified nurse midwife to whom a woman has been referred to send information concerning care for the woman to her primary care provider, in order to promote ongoing management of her care and continuity of care. However, failure of an obstetrician, gynecologist, or certified nurse midewife to provide such information shall not in any way result in financial or other penalties being imposed by the plan on either the patient or the primary care provider.

D. All managed care plans subject to subsection C shall keep a log on file of all denied requests for referrals to, and denials of preauthorizations of care provided by, an obstetrician, gynecologist, or certified nurse midwife who is participating and available under the plan that have been appealed. The log shall indicate the date of each request, the reason for each denial, and the final outcome of each appeal. The log of denied requests mat have been appealed shall not include patient identifying information. The log shall be made available upon request to the Division of Insurance.

E. Nothing in this regulation shall be construed to require a managed care plan to make or approve a referral to an obstetrician, gynecologist, or certified nurse midwife who is not a participating provider under the plan. Also, nothing in this regulation shall be construed to require a managed care plan to include in its plan of coverage specific obstetrical or gynecological services except to the extent otherwise required by law or regulation.

Section 6. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of penalties, issuance of cease and desist orders, and/or suspensions or revocations of license.

Section 7. Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

Section 8. Effective Date

This amended regulation is effective on March 1, 2000.

Section 9. History

1. Originally effective December 30, 1996 for health coverage plans issued or renewed on or after January 31, 1997.

2. Amended March 1, 2000 to include access to certified nurse midwives.

Amended Regulation 4-2-17 PROMPT INVESTIGATION OF HEALTH PLAN CLAIMS INVOLVING

UTILIZATION REVIEW AND DENIAL OF BENEFITS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.).

Section 2 Background and Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 10 3 1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review and certain denials of benefits for treatment, as described herein. Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information. This regulation replaces Colorado Emergency Regulation 05-E-5 in its entirety.

This regulation is designed to provide minimum standards for handling appeals and grievances involving utilization review determinations and certain denials of benefits for treatments excluded by health coverage plans.

Section 3 Applicability and Scope

The provisions of this regulation shall apply to all health coverage plans, but shall not apply to automobile medical payment policies, worker's compensation policies or property and casualty insurance. Where a decision concerning a claim is not based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation, except this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Section 4 Definitions [1]

A. "Adverse determination" means a determination by a health carrier or its designee that request for a benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination also includes a denial for a benefit excluded by a health coverage plan for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

C. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

D. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

E. "Complaint" means a written communication primarily expressing a grievance.

F. "Designated representative" means:

1. A person, including the treating health care professional or a person authorized by Paragraph 2 of this Subsection F., to whom a covered person has given express written consent to represent the covered person; or

2. A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, or a proxy; or

3. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

G. "Discharge planning" means the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.

1 In addition to the terms defined in this section, the following terms are defined in statute (see Section 10-16-102 , C.R.S.): "carrier" , "covered person" , and "health coverage plan" .

H. "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

I. “Grievance” means a circumstance regarded as a cause for protest, including the protest of an adverse determination.

J. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

K. “Life or limb threatening emergency” shall have the same meaning as defined in Section 10-16-407(2), C.R.S.

L. “Medical professional” means an individual licensed pursuant to the “Colorado Medical Practice Act” , article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the “Dental Practice Law of Colorado” , article 35 of title 12, C.R.S., acting within his or her scope of practice.

M. “Prospective review” means utilization review conducted prior to an admission or course of treatment.

N. “Provider” shall have the same meaning as defined in Section 10-16-102(36), C.R.S.

O. “Retrospective review” means any utilization review that is not prospective review, but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

P. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

Q. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before an individual can be transferred.

R. “Urgent care request” means:

1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination that,

    a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently, or

    b. In the opinion of a physician with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

2. Except as provided in Paragraph 3 of this Subsection R., in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

3. Any request that a physician with knowledge of the covered person’s medical condition determines and states is an urgent care request within the meaning of Paragraph 1 shall be treated as an urgent care request.

S. “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification,

concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Compliance Requirements

A. A health carrier that does not use a procedure for investigating claims involving utilization review that is consistent with this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

(Section 10-3-1104(1)(h)(IV), C.R.S.)

B. A health carrier that uses standards in the review of claims involving utilization review that are not in compliance with the rules contained in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier use reasonable standards for the prompt investigation of claims.

(Section 10-3-1104(1)(h)(III), C.R.S.)

C. A health carrier that does not investigate claims involving utilization review within the time frames set out in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly investigate claims.

(Section 10 3 1104(1)(h)(II), C.R.S.)

D. A health carrier that does not follow the procedures for explaining the basis of a utilization review decision set forth in this regulation shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim.

(Section 10 3 1104(1)(h)(XIV), C.R.S.)

E. A health carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information.

(Section 10-3-1104(1)(h)(IV), C.R.S.)

Section 6 Standard Utilization Review

A. A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. Prospective review determinations.

1. Time period for determination and notification.

    a. Subject to Subparagraph b. of Paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request. Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.

    b. The time period for making a determination and notifying the covered person of the determination pursuant to Subparagraph a. of Paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

        (i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

        (ii) Notifies the covered person prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

    c. If the extension under Subparagraph b. of Paragraph 1. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

        (i) Specifically describe the required information necessary to complete the request; and

        (ii) Give the covered person at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

2. Failure to meet the health carrier's filing procedures.

    a. Whenever the health carrier receives a prospective review request from a covered person that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

    b. Required notice.

        (i) The notice required under Subparagraph a. of Paragraph 2. shall be provided, as soon as possible, but in no event later than five (5) days following the date of the failure.

        (ii) The health carrier must provide the notice in writing.

    c. The provisions of Paragraph 2. shall apply only in the case of a failure that:

        (i) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

        (ii) Is a communication that refers to a specific covered person, a specific

medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

3. For an adverse determination regarding a prospective review decision that occurs during a covered person's hospital stay or course of treatment, the health care service or treatment that is the subject of an adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the carrier.

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E.

2. Time period for determination and notification.

a. The time period for making a determination and notifying the covered person of the determination pursuant to Paragraph 1. may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:

(i) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(ii) Notifies the covered person prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

b. If the extension under Subparagraph a. of Paragraph 2. is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall:

(i) Specifically describe the required information necessary to complete the request; and

(ii) Give the covered person at least thirty (30) days from the date of receipt of the notice to provide the specified information.

D. Calculation of time periods.

1. For purposes of calculating the time periods within which a determination is required to be made under Subsections B and C, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

2. Extensions.

a. If the time period for making the determination under Subsection B. or C. is extended due to the covered person's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled

from the date on which the health carrier sends the notification of the extension to the covered person until the earlier of:

(i) The date on which the covered person responds to the request for additional information; or

(ii) The date on which the specified information was to have been submitted.

b. If the covered person fails to submit the information before the end of the period of the extension, as specified in Subsection B. or C., the health carrier may deny the certification of the requested benefit.

E. Requirements for adverse determination notifications.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reason or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

e. If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph e. of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and

h. A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;

2. A health carrier must provide the notice required under this section in writing, either on paper

or electronically.

Section 7 Expedited Utilization Review

A. Procedures.

1. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and for making and notifying covered persons of expedited utilization review with respect to urgent care requests. For purposes of this section, "covered person" includes the designated representative of a covered person.

2. Notification requirements.

a. As part of the procedures required under Paragraph 1., a health carrier shall provide that, in the case of a failure by a covered person to follow the health carrier's procedures for filing an urgent care request, the covered person shall be notified of the failure and the proper procedures to be following for filing the request.

b. The notice required under Subparagraph a. of this paragraph:

(i) Shall be provided to the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request; and

(ii) Must be in writing.

c. The provisions of this paragraph apply only in the case of a failure that:

(i) Is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

B. Urgent care requests.

1. Notification requirements for carrier determinations.

a. For an urgent care request, unless the covered person has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health coverage plan, the health carrier shall notify the covered person and the covered person's provider of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the health carrier.

b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

2. Notification requirements for insufficient information.

a. If the covered person has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.

b. The health carrier shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information, as provided in Subparagraph a. of this paragraph.

c. The health carrier shall notify the covered person and the covered person's provider of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

(i) The health carrier's receipt of the requested specified information; or

(ii) The end of the period provided for the covered person to submit the requested specified information.

d. If the covered person fails to submit the information before the end of the period of the extension, as specified in Subparagraph b. of this paragraph, the health carrier may deny the certification of the requested benefit.

e. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

C. Concurrent urgent care review requests.

1. For concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments authorized, if the request is made at least twenty-four (24) hours prior to the expiration of the authorized period of time or authorized number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person and the covered person's provider of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the health carrier's receipt of the request.

2. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

D. For purposes of calculating the time periods within which a determination is required to be made under Subsection B. or C., the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

E. Adverse determination notification requirements.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

a. An explanation of the specific medical basis for the adverse determination;

b. The specific reasons or reasons for the adverse determination;

c. Reference to the specific plan provisions on which the determination is based;

d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

e. If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph e. of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and

h. A description of the health coverage plan's expedited review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;

2. Notification requirements.

a. A health carrier may provide the notice required under this section orally, in writing or electronically.

b. If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Section 8 Emergency Services

A. A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist 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. Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from

a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.

B. Health maintenance organizations shall also comply with the life or limb threatening emergency coverage provisions of Section 10-16-407(2), C.R.S., in reviewing claims for emergency services necessary to screen and stabilize a covered person.

Section 9 Peer-to-Peer Conversation

A. In a case involving a prospective review determination, a health carrier shall give the provider rendering the service an opportunity to request on behalf of the covered person a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination. Such a request may be made either orally or in writing.

B. The peer-to-peer conversation shall occur within five (5) days of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) days.

C. If the peer-to-peer conversation does not resolve the difference of opinion, the adverse determination may be appealed by the covered person. A peer-to-peer conversation is not a prerequisite to a first level review or an expedited review of an adverse determination.

D. For the purposes of Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1 concerning complaints and complaint records, a request for a peer-to-peer conversation shall not be considered a complaint.

Section 10 First Level Review

A. A health carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request. The procedures shall specify whether a first level review request must be in writing or may be submitted orally. The procedures shall also allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision.

B. A first level review shall be available to, and may be initiated by, the covered person. For purposes of this section, “covered person” includes the designated representative of a covered person.

C. Pursuant to Section 10-3-1104(1)(i), C.R.S., all written requests for a first level review must be entered into the carrier’s complaint record.

D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, a covered person may file a grievance with the health carrier requesting a first level review of the adverse determination. In order to secure a first level review after the receipt of the notification of a benefit denied due to a contractual exclusion, the covered person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply.

E. Conduct of first level reviews.

1. First level reviews shall be evaluated by a physician who shall consult with an appropriate

clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. If the appeal is pursuant to Section 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

F. Covered person's rights.

1. A covered person does not have the right to attend or to have a representative in attendance at the first level review, but the covered person is entitled to:

   a. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review.

      For review of a benefit denial due to a contractual exclusion, the covered person shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply; and

   b. Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

2. For purposes of Subparagraph 1.b. of this subsection, a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

   a. Was relied upon in making the benefit determination;

   b. Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

   c. Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

   d. Constitutes a statement of policy or guidance with respect to the health coverage plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

G. Notification requirements.

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph 2. or 3.

2. With respect to a request for a first level review of an adverse determination involving a

prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review.

3. With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review.

H. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Subsection G., the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

I. The decision issued pursuant to Subsection G. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers" .);

2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;

3. The reviewers' decision in clear terms; and

4. A reference to the evidence or documentation used as the basis for the decision.

J. A first level review decision involving an adverse determination issued pursuant to Subsection G. shall include, in addition to the requirements of Subsection I. :

1. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

2. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection F.2., to the covered person's benefit request;

3. If the reviewers relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

4. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

5. If applicable, instructions for requesting:

    a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Paragraph 3. of this subsection; and

    b. The written statement of the scientific or clinical rationale for the determination, as provided in Paragraph 4. of this subsection.

6. A description of the process to obtain a voluntary second level review, including:

    a. The written procedures governing the voluntary second level review, including any required time frames for the review;

    b. The right of the covered person to:

        (i) Request the opportunity to appear in person before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, who have appropriate expertise, who were not previously involved in the appeal, and who do not have a direct financial interest in the outcome of the review;

        (ii) Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable;

        (iii) Present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the review meeting;

            (a) A copy of the materials the covered person plans to present or have presented on his or her behalf at the review should be provided to the health carrier at least five (5) days prior to the date of the review meeting.

            (b) Any new material developed after the five-day deadline shall be provided to the carrier when practicable;

        (iv) Present the covered person's case to the reviewer or review panel;

        (v) If applicable, ask questions of the reviewer or review panel; and

        (vi) Be assisted or represented by an individual of the covered person's choice, including counsel, advocates, and health care professionals;

    c. A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker.

d. A description of the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination.

Section 11 Voluntary Second Level Review

A. A carrier shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision. The purpose of the voluntary review process is to give the covered person the opportunity to explain their grievance and to provide any relevant evidence in support of their claim for benefits.

B. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. A complaint record entry shall be made for all voluntary second level reviews, pursuant to Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1.

D. Within thirty (30) days after the date of receipt of a notice of an adverse determination, a covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination.

E. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

F. Procedures.

1. With respect to a voluntary second level review of a first level review decision, the denial shall be reviewed by a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, who have appropriate expertise in relation to the case presented by the covered person. The reviewer or review panel, shall meet the following criteria: were not previously involved in the appeal and who do not have a direct financial interest in the appeal or outcome of the review. The reviewer or the review panel shall have the legal authority to bind the health carrier to the reviewer's or review panel's decision.

G. A health carrier's procedures for conducting a voluntary second level review shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. The covered person shall be notified in writing at least twenty (20) days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

2. Notice requirements. The notice to the covered person of the review date shall include:

a. The right of the covered person to present written comments, documents, records and other material relating to the request for benefits for the reviewer or review panel to consider when conducting the review both before and, if applicable, at the

review meeting.

b. The right of the covered person to receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided by the carrier when practicable.

c. The responsibility of the covered person to submit a copy of the materials that the covered person plans to present or have presented on his or her behalf at the review to the health carrier at least five (5) days prior to the date of the review meeting. Any new material developed after the five-day deadline shall be provided to the carrier when practicable.

d. The responsibility of the covered person to, within seven (7) days in advance of the review, inform the carrier if the covered person intends to have an attorney present to represent such person's interests. If the covered person decides to have an attorney present after the seven-day deadline, notice will be provided to the carrier when practicable.

e. The health carrier shall use this notification to advise the covered person if it intends to have an attorney present to represent the interests of the health carrier.

f. The health carrier shall use this notification to advise the covered person that the plan shall make an audio or video recording of the review unless neither the covered person nor the health carrier wants the recording made . The notice shall advise that this recording shall be made available to the covered person and that if there is an external review, the audio or video recording shall, at the request of either party, be included in the material provided by the carrier to the reviewing entity.

3. Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate, at the health carrier's expense , by telephone conference call. A carrier may also offer video conferencing or other appropriate technology.

4. In conducting the review, the reviewer or review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person pursuant to Section 10.J.6.b., without regard to whether the information was submitted or considered in reaching the first level review decision. If the appeal is pursuant to Section 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

5. The reviewer or review panel shall issue a written decision, as provided in Subsection H., to the covered person within seven (7) days of completing the review meeting.

6. For purposes of calculating the time periods within which a decision is required to be made and notice provided, the time period shall begin on the date the request for a voluntary second level review is filed with the health carrier in accordance with the health carrier's procedures for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

H. A decision issued pursuant to Subsection G. shall include:

1. The name(s), title(s) and qualifying credentials of the reviewer or members of the review panel;

2. A statement of the reviewer's or the review panel's understanding of the covered person's request for review of an adverse determination;

3. The reviewer's or the review panel's decision in clear terms;

4. A reference to the evidence or documentation used as the basis for the decision;

5. For a voluntary second level decision issued involving an adverse determination:

   a. The specific reason or reasons for the adverse determination, including the specific plan provisions and medical rationale;

   b. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Section 10.F.2., to the covered person's benefit request;

   c. If the reviewer or review panel has relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

   d. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

   e. If applicable, instructions for requesting:

      (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph c. of this paragraph; and

      (ii) The written statement of the scientific or clinical rationale for the determination, as provided in Subparagraph d. of this paragraph;

   f. A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Colorado Insurance Regulation 4-2-21.

Section 12 Expedited Review of an Adverse Determination

A. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. A health carrier shall also provide an expedited review to a request for a benefit for a covered person who has received emergency services but has not been discharged from a facility. The procedures shall allow a covered person to request an expedited review under this section orally or in writing. The procedures shall also allow the

covered person to identify providers to whom the health carrier shall send a copy of the review decision.

B. An expedited review shall be available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. Pursuant to Section 10-3-1104(1)(i), C.R.S., all written requests for an expedited review must be entered into the carrier's complaint record.

D. Expedited appeal evaluations.

1. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case under review. (For the purposes of this section, the clinical peers shall be called "the reviewers" .) The clinical peer or peers shall not have been involved in the initial adverse determination.

2. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.

E. Covered person's rights.

1. A covered person does not have the right to attend or to have a representative in attendance at the expedited review, but the covered person is entitled to:

a. Submit written comments, documents, records and other materials relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

b. Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits, as described in Section 10 .F.1.b.

F. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of the covered person by telephone, facsimile or similar expeditious method available.

G. In an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on the covered person's behalf as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

H. A health carrier shall provide written confirmation of its decision concerning an expedited review within three (3) days of providing notification of that decision, if the initial notification was not in writing.

I. In the case of an adverse determination, the written decision shall contain the provisions specified in Sections 10.I . and 10.J. of this regulation.

J. For purposes of calculating the time periods within which a decision is required to be made under Subsection G., the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures

for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

K. In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may request a voluntary second level appeal or request an independent external review.

L. A health carrier shall not provide an expedited review for retrospective adverse determinations.

Section 13 Enforcement

Noncompliance with the requirements and time frames specified in this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of the certificate of authority. Among others, the penalties provided for in Sections 10 3 1108 and 10-3-1110(2), C.R.S., may be applied.

Section 14 Severability

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

Section 15 Effective Date

This amended regulation is hereby effective on February 1, 2006.

Section 16 History

1. Originally promulgated effective July 1, 1997.

2. Amended effective April 1, 2000.

3. Amended effective April 1, 2004 to comply with ERISA claims/appeals procedures.

4. Amended effective October 1, 2004, to correct internal references and to provide clarification with respect to the expedited appeal.

5. Emergency Regulation 05-E-5 effective January 1, 2006.

6. Amended effective February 1, 2006 .

Amended Regulation: 4-2-18 Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions

Section 6 Enforcement

Section 7 Severability

Section 8 Effective Date

Section 9 History

Section 1. Authority

This regulation is promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S.

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10- 16-118(1)(b), C.R.S. he purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

B. "Student health plan" means a health benefit plan that covers the students of an educational institution.

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in the federal regulations incorporated below.

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:

   45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These

sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

4. Later amendments to, or editions of, the above-referenced federal regulations are not included in this regulation. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated federal regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

5. Copies of the incorporated federal regulations may be obtained or examined from the Commissioner's office by contacting the Assistant to the Commissioner at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The above-referenced federal regulations may also be examined at any state publications depository library.

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. owever, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.

C. Maximum six (6) month pre-existing condition exclusion period for group health plans.

Colorado law prohibits group health plans from imposing a pre-existing condition limitation period that exceeds six (6) months, except with respect to late enrollees as provided for in Section 10-16-118(1)(c), C.R.S. ll references in the federal regulations to twelve (12) month pre-existing condition limitations for group health benefit plans are not applicable in Colorado.

D. Student health plans are considered group health plans.

Colorado law considers student health benefit plans to be group plans. As such, student health plans shall comply with the group health benefit plan provisions of Colorado law including those

related to pre-existing condition limitations.

E. Children's Basic Health Plan is considered a group health plan.

Colorado law considers the Children's Basic Health Plan (also known as CHP+) to be a group plan. As such, carriers offering coverage through the Children's Basic Health Plan shall comply with the group health benefit plan provisions of Colorado law.

F. Treatment of late enrollees.

Colorado law requires late enrollees (i.e., those individuals who did not enroll when initially offered coverage and who are not special enrollees pursuant to section 10-16-102(26), C.R.S.) to be enrolled upon request. However, late enrollees are subject to longer pre-existing condition periods, affiliation periods, and waiting periods for coverage, as provided for in Section 10-16-118(1)(c), C.R.S.

Section 6. Enforcement

Noncompliance with this rule may result, after notice and opportunity for hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws including the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of certificates of authority.

Section 7. Severability

In the event any part of this rule or application of it to any person or circumstance is determined to be invalid for any reason, the remainder of the rule shall not be affected.

Section 8. Effective Date

This amended rule is effective October 1, 2004.

Section 9. History

1. Originally issued as Emergency Regulation 97-E-6, effective July 31, 1997.

2. Issued as Regulation 4-2-18, effective October 30, 1997.

3. Amended, effective November 1, 1999.

4. Amended, effective October 1, 2004.

Amended Regulation 4-2-19 Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One

Section 6 Enforcement

Section 7 Severability

Section 8 Effective Date

Section 9 History

1. Authority

This regulation is promulgated pursuant to Sections 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S.

2. Basis And Purpose

The purpose of this regulation is to establish and implement rules concerning health benefit plans marketed and/or newly issued to self-employed business groups of one on or after October 1, 2004. In some cases such plans are exempt from Colorado's small group guarantee issue laws, pursuant to Section 10-16-105.2(1)(c), (d) and (3), C.R.S. The purpose of the 2004 amendment to this regulation is to bring the regulation into compliance with recent statutory changes.

3. Applicability And Scope

This amended regulation shall apply to individual health benefit plans marketed and/or newly issued to self-employed business groups of one on or after October 1, 2004.

4. Definitions

A. "Self-employed business group of one" means, pursuant to Section 10-16-105(1)(c)(I), C.R.S., that type of business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees.

B. "Health benefit plan" shall have the same meaning as defined in Section 10-16-102(21)(a), which includes high deductible health savings account (HSA) plans.

5. Rules

A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:

1. Pursuant to Section 10-16-105.2(1)(c)(I)(A), C.R.S., the carrier issuing the policy determines whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. A copy of the completed form shall be kept on file with each application. In addition, pursuant to Section 10-16-102(6)(c), C.R.S., a carrier may require all business group of one applicants to supply certain tax and withholding documents in order to determine if an applicant meets the definition of a business group of one. Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one. An applicant who does not meet this test falls into one of two categories. Either:

a) The applicant is a small employer that is not a self-employed business group of one and thus any plan sold to such person is subject to the small group laws of Colorado, pursuant to Section 10-16-105.2(1)(a), C.R.S.; or

b) The applicant is neither a small employer, nor a self-employed business group of one, nor any other person covered by the small group laws of Colorado (see Section 10-16-105.2(1), C.R.S.) and thus any plan sold to such person is not subject to this regulation but is subject to the other laws of Colorado relating to individual health benefit plans.

2. Pursuant to Section 10-16-105.2(1)(c)(I)(B), C.R.S., the carrier issuing the individual health benefit plan accepts or rejects a self-employed business group of one who applies for coverage and, if such person is applying for family coverage, his/her entire family (all dependents), unless the applicant waives coverage for a family member who has other coverage in effect. A carrier shall meet this family coverage requirement by:

   a) Asking each self-employed business group of one applicant requesting coverage for himself/herself and one or more dependents for the names of all his/her dependents;

   b) Where the applicant waives coverage for a family member, keeping on file with the application a signed statement from the applicant that he/she is waiving coverage for a dependent because that person already has other coverage in effect and shall state what that coverage is and when it became effective; and

   c) Where a self-employed business group of one is rejected for individual coverage because one or more family members fail to meet normal and actuarially-based underwriting criteria, the carrier shall clearly state this as part of the reason for the denial and shall notify the applicant in writing of the availability of coverage for his/her whole family under a small group policy.

3. If, pursuant to Section 5.A.2 of this regulation, a carrier rejects an application by a self-employed business group of one for coverage under an individual plan, and if that same carrier sells coverage in both the individual and small group markets, then pursuant to Section 10-16-105.2(1)(c)(I)(C), C.R.S., the carrier notifies the applicant of the availability of small group coverage both through the small group market and through the carrier. The notice shall inform the applicant of his/her guarantee issue rights as detailed in Section 10-16-105(7.3)(a) and (c), C.R.S. This notice shall be in writing and shall be included as part of the denial of individual coverage letter. A copy of the denial letter and the notice concerning the availability of small group coverage shall be maintained by the carrier in the file with the original application.

4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:

   a) The carrier, as part of its application form, shall require each self-employed business group of one purchasing an individual health benefit plan pursuant to Section 10-16-105.2(1)(c)(I) to read and sign a disclosure form, as proscribed by the Division of Insurance, attesting that they understand that they are forfeiting their rights to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three (3) years after the date of purchase, unless a small employer carrier voluntarily permits the purchase of a business group of one policy within that three-year period.

b) The carrier must provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-16-105.2(1)(c)(I)(D), C.R.S.

B. Material failure by a carrier or its representative to comply with the requirements of Part A of Section 5 of this regulation will result in individual policies sold to self-employed business groups of one becoming subject to Colorado's small group laws.

C. A small employer carrier may reject for coverage under a small group plan a self-employed business group of one otherwise eligible for small group coverage if, at the time of application for small group coverage, the small employer carrier determines that the self-employed person has in place, or within the immediately preceding thirty (30) days has had in place, an individual health benefit plan, other than a short-term policy, that meets the requirements of Part A of Section 5 of this regulation (and any applicable statutory provisions) and such individual health benefit plan has been in place for less than three (3) years.

The small employer carrier shall make this determination by requesting, in writing, from the individual carrier from whom the self-employed business group of one has had coverage, verification that the coverage was or was not issued pursuant to Section 10-16-105.2(1)(c)(I), C.R.S., and this regulation. The small employer carrier shall also request information as to how long the coverage was or has been in place if such coverage was issued pursuant to Section 10-16-105.2(1)(c)(I), C.R.S., and this regulation.

Requests for such verification shall be answered in writing, be signed by a representative of the individual carrier, and shall be responded to within five (5) business days of the date the request was received.

6. Enforcement

Noncompliance with this regulation is a violation of Section 10-3-1104, C.R.S., including but not limited to Subsection 10-3-1104(1)(a)(I), C.R.S., and subject to the sanctions specified in Section 10-3-1108, C.R.S., including the imposition of fines and the suspension or revocation of certificates of authority.

7. Severability

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

8. Effective Date

This amended regulation is effective on October 1, 2004.

9. History

1. Original regulation effective November 1, 1997.

2. Amended regulation hearing September 8, 1999; effective November 1, 1999.

Following Sections were amended: 2, 5, 8, and Appendices A and B.

3. Amended regulation effective January 1, 2002.

Following sections were amended: 2, 3, 5, 6, and Appendices A.

4. Amended regulation effective October 1, 2004.

Amended Regulation: 4-2-20 Concerning the Colorado Health Benefit Plan Description Form

Section 1. Authority

This regulation is promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S.

Section 2. Basis and Purpose

The purpose of this regulation is to establish and implement rules concerning the format for, elements of, and issuance of a Colorado Health Benefit Plan Description Form, pursuant to Section 10-16-108.5(11)(b), C.R.S. As required by law, the form is designed to facilitate comparison of different health plans by persons interested in purchasing or obtaining coverage under a health benefit plan. As also required by law, this regulation sets out procedures for carriers to make available a Colorado Health Benefit Plan Description Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer. This regulation is being changed due to recent changes in Colorado insurance laws and in response to concerns from interested parties.

Section 3. Applicability and Scope

This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after January 1, 2005.

Section 4. Rules

A. Effective January 1, 2005, all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage shall make available to a producer or consumer through electronic means or hard copy, a completed copy of the Colorado Health Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer as one of the final choices from which the ultimate selection will be made, except as provided in Part B of Section 4 of this regulation.

B. Carriers marketing or providing a Medicare supplemental plan will be deemed to have met the requirement of Part A of Section 4 of this regulation if, in lieu of the Colorado Health Plan Description Form, they make available for each such plan a Medicare supplement outline of coverage as prescribed in Colorado insurance regulation 4-3-1, 3 C.C.R. 702-4. Carriers shall make available the Medicare supplement outline of coverage pursuant to Part E of Section 4 below.

C. Carriers shall use the exact format found in Appendix A for the Colorado Health Plan Description Form, including all headings, notes, row numbers, and footnotes. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a landscape rather than a portrait page layout format, but carriers shall follow the exact requirements and use only the choices set forth in the directions found in Appendix B of this regulation. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to Section 10-3-1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

D. Carriers shall follow the directions for completing the Colorado Health Plan Description Form found in Appendix B of this regulation.

E. Carriers shall provide a Colorado Health Plan Description Form that is specific with respect to the particular policy provisions of the policy (e.g., individual deductible = $500 per year) as follows:

1. Automatically, as part of the health benefit plan description materials given to employees or members of a group, association or health care cooperative who have the option of selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and thereafter during any open enrollment period;

2. Automatically within three (3) business days of a potential policyholder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made (e.g., “I am interested in the Gold Plan, the $500 deductible PPO plan, your HMO plan with vision care coverage, etc,” or “I want to purchase your Plan 200, $5 copay HMO plan,” etc.);

3. Upon request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier; and

4. Upon request within three (3) business days to a producer on behalf of any person, group, association, or health care cooperative that is interested in coverage or is covered by a health benefit plan of the carrier.

F.

1. Carriers shall prominently include with all marketing materials the following notice:

   "Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier."

2. The carrier shall ensure that the form is given to the person making the request within three (3) business days of receipt of such request. The request may be made orally or in writing and may be made to either a carrier or a producer.

G. Concerning the carrier’s obligation contained in Part E(1) of Section 4 to make the health benefit plan description form available to employees, or members of a group, association, or health care cooperative, a carrier is in compliance if:

1. The carrier provides the health benefit description form to the group, association, or health care cooperative, or to a producer on behalf of the group, association, or health care cooperative, or to an individual; or

2. The carrier determines that the employer has developed and will distribute or has distributed a conforming grid.

   a. A grid is conforming if an employer offers an employee a choice of health plans and compares the benefits for the plans on a grid that meets all the following requirements:

      (1) The grid must follow the exact format contained in Appendix A for the Colorado Health Benefit Plan Description Form, including the labeling

and numerical identification of rows and columns, the headings, the footnotes, and the notes, except as set forth in subparagraph (b), below.

(2) At the employer's sole discretion, the grid also may include additional rows, as long as the numbering of those rows does not interfere with the ordering and numbering of rows established in Appendix A. For example, the "PRESCRIPTION DRUGS" row is always row 11 on the grid; the "HOSPICE CARE" row is always row 26 on the grid. In addition, the employer grid could include more rows (e.g., "10AINFERTILITY TREATMENT," "11A. CONTRACEPTIVES," "31A NATUROPATHY").

(3) The benefit descriptions in the grid must follow exactly the directions contained in Appendix B of this regulation for completing the grid, except as set forth in subparagraph (b), below.

(4) At the employer's sole discretion, the benefit descriptions may include additional relevant information.

(5) The grid must be given to all new enrollees, to all employees eligible for coverage during any open enrollment periods, and, upon request, to any covered employee and any person interested in obtaining coverage.

(6) The grid may contain several columns comparing the benefits of the different plans available to the employer's employees, which shall also conform to this regulation.

b. Where employees of an employer or members of a health care purchasing cooperative are given a choice of two or more plans, the form may be further modified as follows. Where a specific benefit for all plans is the same, the comparison grid may simply describe that same benefit once, across all columns, for all plans, or state "see rider" across all columns, for all plans. For example:

EXAMPLE

	HMO A	HMO B	PPO Z
		In-Network	Out-of- Network
28. DENTAL CARE	See rider.		
29. VISION CARE	All plans cover up to $50 per year toward eyeglasses.		

c. Nothing in this regulation shall be construed to require an employer to develop or use a grid for comparing employee benefit plan choices.

H. With respect to the specific Colorado Health Plan Description Form required to be made available by carriers pursuant to Part E(1) of Section 4, a carrier shall develop a separate Colorado Health Plan Description Form for each of its policies, contracts, and plans of benefits. If a carrier offers a policy with a choice of copayments, coinsurance levels, deductibles, lifetime maximums, annual maximums, and/or other benefit maximums, minimums or restrictions, the carrier shall provide a separate Colorado Health Plan Description Form specific to the particular benefits of the policy being sold, marketed, or that is in place.

I. The Colorado Health Plan Description Form is designed to be a stand-alone piece describing a health

benefit plan. The forms should not include attachments, except that a carrier may:

1. Attach a list of exclusions developed pursuant to Part K of Section 4 of this regulation;

2. Attach information on premiums;

3. Attach information on riders;

4. Include as an attachment information specifying the plan's cancer screening coverages and their respective parameters, as required by Section 10-16-108.5(11)(c), C.R.S.;

5. Include at the end of the form or as an attachment information that is statutorily required of marketing materials (e.g., for managed care plans, disclosure of the existence and availability of an access plan, as required pursuant to Section 10-16-704(1), (2) and (9), C.R.S.); or

6. Include the Optional Attachment, "Selected Benefit Descriptions," that appears at the end of the Colorado Health Plan Description Form.

J. A carrier shall make a list of policy exclusions available immediately upon request (but in no event more than three (3) business days after the request) for each of its health benefit plans.

K. The Colorado Health Plan Description Forms developed for each policy, contract, and plan of benefits shall be in standard, easy-to-read type sizes and fonts, of no less than 10 points.

Section 5. Enforcement

Noncompliance with this regulation is a violation of Section 10-3-1104, C.R.S., and subject to the sanctions specified in Section 10-3-1108, C.R.S., including the imposition of fines and the suspension or revocation of insurance licenses and/or certificates 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.

Section 7. Effective Date

This amended regulation is effective on January 1, 2005.

Section 8. History

Hearing date: September 10, 1997; Effective: November 15, 1997

Hearing date: August 4, 1998: Effective date: September 30, 1998.

- Amended Sections 1,2,3,4,7, Appendix A, and Appendix B.

Hearing date: March 2003, Effective: January 1, 2004.

Hearing date: August 4, 2004; Effective: January 1, 2005

NOTE: An unofficial copy of this amended regulation, including the description form, is available on the Colorado Division of Insurance web site on the Internet at: http://www.dora.state.co.us/insurance/regs

Appendix A

Colorado Health Plan Description Form

Name of Carrier
Name of Plan

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	
2. OUT-OF-NETWORK CARE COVERED?1	
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	

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.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE2a) Individualb) Family		
5. OUT-OF-POCKET ANNUAL MAXIMUM3a) Individualb) Familyc) Is deductible included in the out-of-pocket maximum?		
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE		
7A. COVERED PROVIDERS		
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?		Not applicable.
8. ROUTINE MEDICAL		

OFFICE VISITS4a) Primary Care Providersb) Specialists		
9. PREVENTIVE CAREa) Children's servicesb) Adults' services		
10. MATERNITYa) Prenatal careb) Delivery & inpatient well baby care5		
11. PRESCRIPTION DRUGS6Level of coverage and restrictions on prescriptions		
12. INPATIENT HOSPITAL		
13. OUTPATIENT/AMBULATORY SURGERY		
14. DIAGNOSTICSa) Laboratory & x-rayb) MRI, nuclear medicine, and other high-tech services		
15. EMERGENCY CARE7, 8		
16. AMBULANCE		
17. URGENT, NON-ROUTINE, AFTER HOURS CARE		
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE9		
19. OTHER MENTAL HEALTH CAREa) Inpatient careb) Outpatient care		
20. ALCOHOL & SUBSTANCE ABUSE		
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY		
22. DURABLE MEDICAL		

EQUIPMENT		
23. OXYGEN		
24. ORGAN TRANSPLANTS		
25. HOME HEALTH CARE		
26. HOSPICE CARE		
27.SKILLED NURSING FACILITY CARE		
28. DENTAL CARE		
29. VISION CARE		
30. CHIROPRACTIC CARE		
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)		

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.10	
33. EXCLUSIONARY RIDERS.Can an individual's specific, pre-existing condition be entirely excluded from the policy?	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION" ?	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
39. What is the main customer service number?		
40. Whom do I write/call if I have a complaint or want to file a grievance?"		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		
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.		
43. Does the plan have a binding arbitration clause?		

Endnotes

1 “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your 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 (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-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

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

5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

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

7 “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.

8 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 copayments apply.

9 “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

10 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.

11 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the

Colorado Division of Insurance for a copy of those procedures.

Optional Attachment

Selected Benefit Descriptions

Colorado Health Plan Description Form Addendum

Name of Carrier
Name of Plan
Individual/Group Name and/or Number (optional)

Benefit	Benefit Level
4. ANNUAL DEDUCTIBLEa) Individualb) Family	
5. OUT-OF-POCKET ANNUAL MAXIMUMa) Individualb) Family	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	
11. PRESCRIPTION DRUGSLevel of coverage and restrictions on prescriptions	
19. OTHER MENTAL HEALTH CAREa) Inpatient careb) Outpatient care	
20. ALCOHOL & SUBSTANCE ABUSE	
22. DURABLE MEDICAL EQUIPMENT	
28. DENTAL CARE	
29. VISION CARE	
30. CHIROPRACTIC CARE	

Appendix B

Directions for Filling Out the Colorado Health Plan Description Form

TOP OF FORM

Carrier and plan names. Fill in complete carrier name on the first line and the name of the plan on the second line. Plans may also include the following information, if they wish to do so, either at the top of the form, at the bottom of the page, or at the end of the document: carrier logo, group identification number, class or division, and effective date.

PART A: TYPE OF COVERAGE

Question 1, Type of Plan. Enter type of plan. Select one of the following choices only: (1)"Medical expense policy," (2) "Hospital expense policy," (3) "Preferred provider plan," (4) "Health maintenance organization (HMO)," (5) "Point of service (i.e., an HMO plan with some out-of-network benefits)," or (6) "Limited service licensed provider network (LSLPN) plan." Note: Plans that have in-network and out-of-network benefits that are not offered by an HMO but which use gatekeepers should enter "Preferred Provider Plan."

Question 2, Coverage for Out-of-Network Care. Indicate if out-of-network care is covered. Select one of the following choices only: (1)"Only for emergency care" ; (2) " Only for emergency and urgent care" ; (3) "Only for specified services; patient pays more for such out-of-network care" [e.g., POS plans]; (4) "Yes, but patient pays more for out-of-network care" [e.g., PPO's]; (5) "Yes; policy makes no distinction between in-network and out-of-network care" [e.g., traditional indemnity plans]. (6) For HMOs that are marketing to small employers or employees of small employers outside of its geographic service area, the following statement must be added in bold, 12 pt. caps:

" INTERESTEDPOLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS."

Question 3, Where Plan Is Available. Indicate where the plan itself is available. This question does not concern the residence of the potential enrollee. Select one of the following choices only: (1) "Plan is available throughout Colorado" ; (2) "Plan is available only in the following areas: [fill in]" ; or (3) "Plan is available throughout Colorado except in the following areas: [fill in]." A note should be added if the Plan is marketed to employers or employees located over state or county lines.

PART B: SUMMARY OF BENEFITS

Questions 4-31: General Directions.

- If the plan has separate in-network and out-of-network benefits (e.g., preferred provider plan), use two columns and label them "In-network" and "Out-of-network."

- If the plan does not make such a distinction (e.g., traditional indemnity plan) replace two columns with a single column labeled "Benefit Levels."

- HMOs may use one rather than two columns to describe their benefits. HMOs that decide to use one column only should label that column as follows: "In-Network Only (out-of network care is not covered except as noted)." Wherever the plan does provide out-of-network care (e.g., emergency care), this should be noted in the appropriate boxes describing benefits. Point of service plans and preferred provider plans should continue to use two columns—one for in-network and one for out-of-network coverage—to describe their plans.

- For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in "See benefit schedule attached" and show actual benefit levels on a separate schedule attached to the form. Carriers that choose to use a separate schedule for the designated questions shall use the form labeled "Selected Benefit Descriptions," which is found at the end of the description form and labeled Optional

Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form.

Question 4, Annual Deductible*. Enter applicable individual and family annual deductibles for the plan as a whole. Indicate whether they are aggregate or separate deductibles. Carriers may identify what services are subject to the deductible by making a text notation next to those services in items 8 through 31 of the Health Plan Description Form. If the plan does not require deductibles, enter “No deductibles.”

Question 5, Out-Of-Pocket Annual Maximum*. Enter applicable out-of-pocket individual and family annual maximums. If the out-of-pocket maximum excludes deductibles and/or copayments, so indicate. If the plan has combined in-network and out-of-network annual out-of-pocket maximums, so indicate. Carriers may identify what deductibles and copayments are included in calculating the out-of-pocket maximums by making a text notation next to any applicable deductibles or copayments in items 8 through 31 of the Health Plan Description Form. If the plan has no out-of-pocket maximum, enter “No out-of-pocket maximum.”

Question 6, Lifetime/benefit Maximum*. Enter lifetime maximum (e.g., “$2 million”) and other benefit maximum that apply to the whole policy (e.g., “$50,000 per year” or “$20,000 per episode of care”). If lifetime/benefit maximums apply to both in-network and out-of-network expenses, so indicate. If the plan has no lifetime maximum, enter “No lifetime maximum.”

Question 7A, Covered Providers. Indicate covered providers. Select one of the following choices only: (1) “[Insert name of provider network]. See provider directory for complete list of current providers” ; (2) “[Insert total number] physicians and [Insert total number] hospitals in Colorado as of [insert date]. See provider directory for complete list of current providers” ; or (3) “All providers licensed or certified to provide covered benefits.”

Question 7B, Accessibility of Providers. One purpose of this question is to get at the so-called “pod” issue. In some plans, once an enrollee selects a PCP, that PCP only refers to a selected subset of otherwise covered network providers, sometimes called a pod. The subset is usually a physician-hospital network that has made special arrangements with the carrier concerning provider payment. An enrollee who wants to be referred to a specialist who is covered by his plan as a network provider but who is not part of his PCP’s pod would have to select a new PCP who practices in the same pod as the specialist in order to get a referral. Select one of the following choices only: Network plans using this kind of pod system should answer “No” ; all other network plans should answer “Yes” . If the answer depends on the service area or some other factor, so indicate (e.g., “Yes, except in Denver and Adams County.”)

A note should be added if the Plan includes network providers located over state or county lines.

Plans that do not use networks should enter: “Not applicable. This is not a network plan.”

Questions 8-30: General Directions.

Show benefit levels, including copayments, coinsurance, and other applicable payment. If deductibles or copayments can vary by provider, disclose how this will apply. Indicate significant benefit limits. If per diem, annual, or per visit maximums apply, show them. If separate deductibles apply, so indicate. Examples: “80% for up to 6 visits per year,” or “80% for generic drugs only,” or “$10 per visit copayment,” or “$50 per day up to $500 per year,” or “50% after separate $100 per year physical therapy deductible,” or “50% for 2 acute care detoxifications per year.” If no coverage is provided for a category of benefit write in “Not covered.” If full coverage is provided, write in “No copayment (100% covered)” . Coinsurance options should reflect the carrier’s reimbursement level.

HMOs that use one rather than two columns to describe their benefits should note in the appropriate boxes where the plan does cover out-of-network care (e.g., emergency care).

Question 8, Routine Medical Office Visits. Indicate coverage for primary care provider and specialist services separately.

Question 9, Preventive Services. Carriers are reminded that Colorado law has benefit mandates regarding the coverage of children's preventive services (all individual and group plans). Indicate coverage for children's and adult preventive services separately. A complete, detailed list of services does not need to be provided.

Question 10, Maternity. Carriers are reminded that Colorado law has benefit mandates regarding maternity care coverage (group plans only). Indicate coverage for prenatal care and for delivery and inpatient well baby care separately.

Question 11, Prescription Drugs*. Indicate the amount of coverage for prescription drugs. Also indicate whether the level of coverage is based on generic versus brand name drugs, use of a prescription drug card, and/or other requirements. Note if separate copayments and deductibles apply. Examples: "Separate $100 deductible. $8 copayment per prescription" ; or "80% generic; 50% brand name drugs" ; or "90% with prescription drug card. Maximum benefit of $200/month" ; or "$5 per prescription for drugs on our approved list only." If a formulary is used, add this statement: "For drugs on our approved list, contact [position title], at [telephone number]."

Questions 12 and 13, Inpatient Hospital and Outpatient/Ambulatory Surgery. See General Directions for Questions 8-30, above.

Question 14, Laboratory & X-ray. If coverage, copayments, or deductibles for diagnostic benefits vary depending on whether they are associated with a medical office visit, so indicate.

Questions 15, 16 and 17, Emergency Care, Ambulance, and Urgent Care. If copayments or deductibles differ by service among emergency care, ambulance, or urgent care, so indicate.

Question 18, Biologically Based Mental Illness Care. For group plans issued or renewed on or after January 1, 1998, carriers must enter: "Coverage is no less extensive than the coverage provided for any other physical illness."

Question 19, Other Mental Health Care*. Carriers are reminded that Colorado law has benefit mandates for group plans regarding the coverage of other, non-biologically based mental health conditions. If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 20, Alcohol & Substance Abuse*. See General Directions for Questions 8-30, above. If coverage varies depending on whether the care is inpatient or outpatient, so indicate. Also indicate if coverage varies depending on whether care is for alcohol versus other substance abuse.

Question 21, Physical, Occupational and Speech Therapy. If benefit levels vary, so indicate. Example: "Physical therapy: 50% maximum for up to six visits per event; Occupational: 80%; Speech: not covered." If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 22, Durable Medical Equipment*. Carriers must indicate benefit level. Carriers may also add the following statement: "See policy for types and circumstances of coverage." If coverage varies depending on whether inpatient or outpatient, so indicate.

Questions 23, 24, 25, 26 and 27. See General Directions for Questions 8-30, above. If coverage

varies depending on whether inpatient or outpatient, so indicate.

Questions 28-30, Dental Care, Vision Care and Chiropractic Care*. Briefly describe coverage, if any, and note if coverage may be obtained either under a separate dental/vision/chiropractic care plan or as an optional benefit. If no coverage is provided, write in "No coverage" .

Question 31, Significant Additional Covered Services. You may list up to five additional covered benefits not already asked about in questions 10-30. Examples: acupuncture; other alternative medical treatments; transportation. Information specifying the plan's cancer screening coverages, as required by Section 10-16-108.5(11)(c), C.R.S., must be included in box 31 if it is not included at the end of the form or attached as allowed by section 4.I.4 of the regulation. Information regarding cancer screening coverages counts as only one (1) of the five (5) additional services that can be listed in this box.

PART C: LIMITATIONS AND EXCLUSIONS

Question 32, Pre-existing Condition Exclusion Period. Select one of the following choices only: (1) "____ months [insert the length of the limitation period] for all pre-existing conditions" ; (and for business groups of one the limitation period may not exceed 12 months.) (2) "____ months [insert the length of the limitation period] for selected pre-existing conditions only; no pre-existing condition limitation for all other conditions. See policy for details." ; (3) "Not applicable; plan does not impose limitation periods for pre-existing conditions." Note: For group plans (except business groups of one) the limitation period may not exceed six (6) months; for business groups of one the limitation period may not exceed 12 months. Individual carriers that use pre-existing exclusion periods shall also add the following to their answer: "unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions." Carriers are reminded that Colorado law governs allowable pre-existing periods for all health benefit plans.

Question 33, Exclusionary Riders. All group carriers must enter "No" . Depending on the policy, individual carriers should enter "Yes" or "No."

Question 34, Definition of a Pre-existing Condition. Enter the definition of a pre-existing condition under this policy. Select one of the following choices only: (1) "Not applicable. Plan does not exclude coverage for pre-existing conditions" ; (2) for group plans: "A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last ___ [insert a number not to exceed 12 for business groups of one and not to exceed 6 for all other group plans] 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" ; or (3) for individual plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within ___ [insert a number not to exceed 12] months immediately preceding the effective date of coverage."

Question 35, Policy Exclusions. All carriers must enter the following language: "Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy." On demand, carriers must give applicants and insureds a complete list of exclusions. Carriers are encouraged, but not required, to list the exclusions in alphabetical order (e.g., custodial care; enteral feedings; growth hormone therapy; health services which are not medically necessary; travel or transportation expenses except for ambulance).

PART D: USING THE PLAN

Questions 36-38: General Directions. If the plan has separate in-network and out-of-network benefits, use two columns and label them "In-network" and "Out-of-network." If the plan does not make such a

distinction (e.g., a traditional indemnity plan), replace two columns with a single column labeled “Using the Plan.”

Questions 36, 37, and 38, Specialty Care, Surgical Procedures, and Provider Charges. In each column, select one of the following choices only: (1)“Yes” or (2)“No.” If the answer is “Yes” , a carrier may expand on the answer to note exceptions to this requirement (e.g, “Yes, except for obstetrical or gynecological care.”)

Question 39, Customer Service Number. Enter your main customer service number for members/insureds.

Question 40, Filing Complaints. Enter name, address and phone number for complaints and grievances.

Question 41, Dissatisfaction With Resolution of Consumer Complaint. Except as noted, all plans enter: “Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202.”

Question 42, Form Number, Group Size, and Short-Term. Enter the policy form number by writing “Policy form # ___ [fill in]” . Indicate whether this is an individual, small, or large group policy. Select one of the following choices only: (1) “Individual” , (2) “Small group only” , (3) “Large group only” , or (4) “Group--all sizes.” Indicate if policy is short-term by writing “short term policy.” Examples: “Policy form # CO-1247, large group.” or “Policy form # 12-30-7, individual, short-term.” Note: If a carrier offers the identical policy in several markets (e.g., large group market, small group market, etc.) then multiple responses may be included here (e.g., "Policy form #CO-1247 large group, and #CO-807 small group."

Question 43, Binding Arbitration. Indicate, with a yes or no, if the plan has binding arbitration.

OPTIONAL ATTACHMENT: SELECTED BENEFIT DESCRIPTIONS

Carriers are not required to use this form. At the carrier's option, with respect to questions 4-6,11, 19-20,22, and 28-30 only, a carrier may describe its benefits with respect to these items on the optional attachment instead of on the main form. A carrier that chooses to do this must write in "See benefit schedule attached" for the designated questions and shall use the form labeled “Selected Benefit Descriptions,” which is found at the end of the description form and labeled Optional Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form. Carriers using the optional attachment must attach it to all health plan description forms.

Endnote:

* For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in “See benefit schedule attached” and show actual benefit levels on a separate schedule attached to the form. Carriers shall use the form labeled “Specific Benefits Selected” which is shown as the Optional Attachment at the end of the form in Appendix A.

Amended Regulation: 4-2-21 External Review of Benefit Denials of Health Coverage Plans

Section 1. Authority

This regulation is promulgated and adopted by the commissioner of Insurance under the authority of § 10-1-109,10-16-109,10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S.

Section 2. Background and Purpose

The purpose of this regulation is to provide standards for the external review process set forth in § 10-16-113.5, C.R.S., including the approval of independent external review entities.

Section 3. Definitions

For purposes of this regulation, the following definitions apply:

A. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

B. “Carrier's final adverse determination” means an adverse determination, as defined in insurance regulation 4-2-17, involving a covered benefit that has been upheld by a carrier at the completion of the carrier's internal appeal process as set forth in insurance regulation 4-2-17.

C. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

D. “Certification,” as used in the definition of “utilization review,” means a determination by a carrier that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or efficiency.

E. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a carrier to determine the necessity and appropriateness of health care services.

F. “Concurrent review” means utilization review conducted during a patient's hospital stay or course of treatment.

G. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health coverage plan.

H. “Designated representative” means:

(1) A person, including the treating health care professional or a person authorized by subsection (2) of this subsection H, to whom a covered person has given express written consent to represent the covered person in an external review; or

(2) A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, or a proxy.

I. “Discharge planning” means the formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.

J. “Disability” shall mean, with respect to a covered person, a physical or mental impairment that substantially limits one or more of the major life activities of such covered person, in accordance with the Americans with Disabilities Act of 1990,42 U.S.C. § 12101.

K. “Facility” means an institution providing health care services, or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

L. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

M. “Health care services” means services for the diagnosis, prevention, maintenance, treatment, cure or relief of a health condition, illness, injury or disease.

N. “Prospective review” means utilization review conducted prior to an admission or a course of treatment.

O. “Protected health information” means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

P. “Retrospective review” means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Q. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a

provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

R. “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 4. Applicability and Scope

The provisions of this regulation shall apply to all health coverage plans that base decisions concerning claims in whole or in part based on utilization reviews. This regulation shall not apply to property and casualty contracts. Where a decision concerning a claim is in no way based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Section 5. Notice and Disclosure of Right to External Review

A.

(1) A carrier shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in (2) of this Subsection A at the time the carrier sends written notice of carrier's final adverse determination.

(2) The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B, including the provisions in the external review procedures that give the covered person or the covered person's designated representative the opportunity to submit new information and including any forms used to process an external review, as specified by the Division of Insurance.

B.

(1) Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

(2) The description required under (1) of this Subsection B shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.

Section 6. Request for External Review

A. Within sixty (60) calendar days after the date of receipt of a notice of a carrier's final adverse

determination pursuant to Section 5A of this regulation, a covered person or the covered person's designated representative may file a request for an external review with the carrier.

B. All requests for external review shall be made in writing to the carrier and must include a completed external review request form as specified by the Division of Insurance.

C. A covered person or covered person's designated representative requesting an expedited external review must include a request for an expedited review in the written request described in Subsection A of this Section 6.

D. All requests for external review shall include a signed consent, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review.

E. A request for external review submitted by the covered person or the covered person's designated representative may include new information, if significantly different from information provided or considered during the internal review process, for consideration by the carrier and the independent external review entity.

Section 7. Exhaustion of Internal Appeal Process

A request for an external review pursuant to Section 8 or 9 of this regulation shall not be made until the covered person has exhausted the carrier's internal appeal process as set forth in insurance Regulation 4- 2-17.

Section 8. Standard External Review

A.

(1) Except as provided in Paragraph (2) of this Subsection A, the carrier, upon receipt of a complete request for an external review pursuant to Section 6 of this regulation, shall deliver a copy of the request to the commissioner within two (2) working days.

(2) If the carrier, before the expiration of the deadline for sending notification to the commissioner, reverses its final adverse determination based on new information submitted by the covered person or the designated representative pursuant to Section 6, Subsection E, the carrier must notify the covered person or the designated representative within one working day of its reversal, electronically, by facsimile, or by telephone, followed by a written confirmation.

B.

(1) Within two (2) working days from the time a request for external review is received from the carrier, the commissioner shall assign an independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. The commissioner shall randomly select an independent external review entity that does not have a conflict of interest, as described in Section 12. Upon assignment, the commissioner shall notify the carrier, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the independent external review entity to which the appeal should be sent.

(2) After notice from the commissioner pursuant to (1) of this Subsection B, the carrier shall notify within two (2) working days the covered person or the designated representative, electronically, by facsimile, or by telephone, followed by a written confirmation. The notice shall include a written description of the independent external review entity that the

commissioner has selected to conduct the external review and information regarding how the covered person or the designated representative may provide the commissioner with documentation regarding any potential conflict of interest of the independent external review entity as described in Section 12 of this regulation.

(3) Within two (2) working days of receipt of notice from the carrier, the covered person or the designated representative may provide the commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed by a written confirmation. If the commissioner determines that the independent external review entity presents a conflict of interest as described in § 10-16- 113.5(4)(b), C.R.S., the commissioner shall assign, within one (1) working day, another independent external review entity to conduct the external review that has been approved pursuant to Section 11 of this regulation. Upon this reassignment, the commissioner shall notify the carrier, electronically, by facsimile, or by telephone, followed by a written confirmation, of the name and address of the new independent external review entity to which the appeal should be sent. The commissioner will notify the covered person or the designated representative in writing of the commissioner's determination regarding the potential conflict of interest and the name and address of the new independent external review entity, if applicable.

(4) In reaching a decision, the assigned independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in insurance Regulation 4-2-17.

C.

(1) Within six (6) working days from the date the carrier receives notice from the commissioner pursuant to paragraph (1) of Section 8B, the carrier shall deliver to the assigned independent external review entity the following documents and information considered in making the carrier's final adverse determination including:

(a) any and all infonnation submitted to the carrier by a health care professional or the covered person or designated representative in support of the request for coverage under the health coverage plan's procedures;

(b) any and all information used by the plan during the internal appeal process to determine the medical necessity, medical appropriateness, medical effectiveness, or medical efficiency of the proposed treatment or service, including medical and scientific evidence and clinical review criteria;

(c) a copy of any and all denial letters issued by me plan concerning the case under review;

(d) a copy of the signed consent form, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review; and

(e) an index of all submitted documents.

(2) Within two (2) working days of receipt of the material specified in Paragraph (1) of this Subsection C, the independent external review entity shall deliver to the covered person or the designated representative the index of all materials that the plan has submitted to the independent external review entity. The carrier shall provide to the covered person or designated representative, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or

federal law concerning the case under review.

(3)

(a) The certified independent external review entity shall notify the covered person or the designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Paragraph (1) of this Subsection C. Within five (5) working days of such a request, the covered person or the designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier.

(b) If the covered person or designated representative or the health care professional of the covered person fails to provide the additional information or the explanation of why additional information is not being submitted within the time frame specified in Paragraph (3) of this Subsection C, the assigned independent external review entity shall make a decision based on the information submitted by the carrier as; required by Paragraph l of this Subsection C.

(4)

(a) If the carrier fails to provide the required documents and information within the time specified in Paragraph (1) of this Subsection C, the assigned independent external review entity may terminate the external review and make a decision to reverse the carrier's final adverse determination.

(b) Immediately upon the reversal under Subparagraph (a) of this Paragraph (4), the independent external review entity shall notify the covered person, if applicable, the covered person's designated representative, the carrier, and the commissioner.

(5) Except as provided in Paragraph (4) of this Subsection C, failure by the carrier to provide the documents and information within the time specified in paragraph (1) of this Subsection C shall not delay the conduct of the external review.

D. The assigned independent external review entity shall review all of the information and documents received pursuant to Subsection C of this Section 8.

E.

(1) Upon receipt of the information permitted to be forwarded pursuant to Section 6E of this regulation, the carrier may reconsider the carrier's final adverse determination that is the subject of the external review.

(2) Consideration of new information by the carrier of the carrier's final adverse determination pursuant to Paragraph (1) of this Subsection E shall not delay or terminate the external review.

(3) The external review may only be terminated if the carrier decides to reverse the carrier's final adverse determination and provide coverage or payment for the health care service that is the subject of the carrier's final adverse determination.

(4)

(a) Within one (1) working day of making the decision to reverse the carrier's final adverse determination, as provided in Paragraph (3), the carrier shall notify the covered person or the covered person's designated representative, the assigned independent external review entity, and the commissioner of its decision, electronically, by facsimile, or by telephone followed by a written confirmation.

(b) The assigned independent external review entity shall terminate the external review upon receipt of the notice from the carrier sent pursuant to Subparagraph (a) of this Paragraph (4).

F. In addition to the documents and information provided pursuant to Subsection C of this Section 8, the assigned independent external review entity, to the extent the documents or information are available, shall review the following:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) Any applicable clinical review criteria developed and used by the carrier, and

(5) Medical and scientific evidence determined to be relevant and appropriate by the independent review entity.

G. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

H.

(1) Except as provided in Paragraph (2) of this Subsection H, within thirty (30) working days after the date of receipt of the request for external review by the carrier, the assigned independent external review entity shall provide written notice of its decision to uphold or reverse the carrier's final adverse determination to:

(a) The covered person;

(b) If applicable, the covered person's designated representative;

(c) The carrier,

(d) The physician or other health care professional of the covered person; and

(e) The commissioner.

(2) The expert reviewer may request that the commissioner extend the deadline for the written notice of the independent external review entity up to ten (10) working days for the consideration of additional information required pursuant to Subsection C(3) of this Section 8.

(3) In addition to the requirements of § 10-16-113.5(10), C.R.S., the independent external review entity shall include in the notice sent pursuant to Paragraph (1) of this Subsection H:

(a) The date the independent external review entity received the assignment from the commissioner to conduct the external review;

(b) The date of its decision; and

(c) An explanation that the external review decision is the final appeal available to the consumer under state insurance law.

(4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination. For concurrent and prospective reviews, the carrier shall approve the coverage within one (1) working day. For retrospective reviews, the carrier shall approve the coverage within five (5) working days. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of the carrier's approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

Section 9. Expedited External Review

A.

(1) Except as provided in Subsection I of this Section 9, a covered person or the covered person's designated representative may make a request for an expedited external review with the carrier if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, would jeopardize the covered person's ability to regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently.

(2) The covered person's or the designated representative's request for an expedited review must include a physician's certification that the covered person's medical condition meets the criteria in Paragraph (1) of this Subsection A.

(3) Upon receipt of a request for an external review pursuant to paragraph (1) of this subsection A, the carrier shall notify and send a copy of the request to the commissioner within one (1) working day electronically or by telephone or facsimile or any other available expeditious method.

B.

(1) Within one (1) working day of the time the commissioner receives a request for an expedited external review, the commissioner shall randomly assign an independent external review entity that has been approved pursuant to Section 11 of this regulation to conduct the review and to make a decision regarding the carrier's final adverse determination. The commissioner shall select an independent external review entity that does not have a conflict of interest with the case, as described in Section 12. Upon assignment, the commissioner shall inform the carrier of the name and address of the independent external review entity to which the appeal should be sent.

(2) Within one (1) working day of notice from the commissioner pursuant to Paragraph (1) of this Subsection B, the carrier shall notify the covered person or designated representative, electronically, by facsimile, or by telephone followed by a written confirmation. The notice shall include a written description of the independent external review entity that the commissioner has selected to conduct the independent review.

C. In reaching a decision, the assigned independent external review entity is not bound by any decisions or conclusions reached during the carrier's utilization review process or the carrier's internal appeal process as set forth in insurance Regulation 4-2-17.

D.

(1) Within three (3) working days of the time the carrier receives the request pursuant to Subsection A, the carrier shall provide or transmit all necessary documents and information, as described in Section 8C(1), considered in making the carrier's final adverse determination to the assigned independent external review entity electronically or by telephone or facsimile or any other available expeditious method.

(2) Within one (1) working day of receiving documents and information as described in Paragraph (1) of this Subsection D, the independent external review entity shall deliver to the covered person or the designated representative an index of all materials that the plan has submitted to the independent external review entity. The carrier shall provide to the covered person or designated representative, upon request, all information supplied to the independent external review entity that is not confidential or privileged under state or federal law concerning the case under review.

E. The certified independent external review entity shall notify, electronically, by facsimile, or by telephone followed by a written confirmation, the covered person or designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to subsection D of this Section 9. The covered person or designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier within two (2) working days of such a request

F. In addition to the documents and information provided or transmitted pursuant to Subsections D and E of this Section 9, the assigned independent external review entity, to the extent the information or documents are available, shall consider the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional' s recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) Any applicable clinical review criteria developed and used by the carrier; and

(5) Documents and information regarding medical and scientific evidence, to the extent the independent review entity considers them appropriate.

G. The independent external review entity shall base its determination on an objective review of relevant medical and scientific evidence.

H.

(1) Except as provided in Paragraph (2) of this Subsection H, within seven (7) working days after the date of receipt of the request for external review by the carrier, the assigned independent external review entity shall:

(a) Make a decision to uphold or reverse the carrier's final adverse determination; and

(b) Notify the covered person, if applicable, the covered person's designated representative, the carrier, the covered person's physician, and the commissioner of the decision.

(2) The expert reviewer may request the commissioner to extend the deadline for the written notice of the independent external review entity up to five (5) working days for the consideration of additional information pursuant to Subsection E of this Section 9.

(3) If the notice provided pursuant to Paragraph (1) of this Subsection H was not in writing, within two (2) working days after the date of providing mat notice, the assigned independent external review entity shall:

(a) Provide written confirmation of the decision to the covered person, if applicable, the covered person's designated representative, the carrier, and the commissioner; and

(b) Include the information set forth in Section 8H(3) of this regulation.

(4) Upon carrier's receipt of the independent external review entity's notice of a decision pursuant to Paragraph (1) of this Subsection H reversing the carrier's final adverse determination, the carrier shall approve the coverage that was the subject of the carrier's final adverse determination within one (1) working day. The carrier shall provide written notice of the approval to the covered person or the designated representative within one (1) working day of receipt of the notice pursuant to Paragraph (1) of this Subsection H. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

I. An expedited external review may not be provided for retrospective adverse determinations.

Section 10. Binding Nature of External Review Decision

A. An external review decision is binding on the carrier and the covered person except to the extent the carrier and covered person have other remedies available under federal or state law; however, the determination of the expert reviewer will create a rebuttable presumption in any subsequent action.

B. A covered person or the covered person's designated representative may not file a subsequent request for external review involving the same carrier's final adverse determination for which the covered person has already received an external review decision pursuant to this regulation.

Section 11. Approval of Independent External Review Entities

A. The commissioner shall approve independent external review entities eligible to be assigned to conduct external reviews under this regulation to ensure that an independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.

B. Application shall be made on a form specified by the commissioner for approving independent external review entities to conduct external reviews.

C. Any independent external review entity wishing to be approved to conduct external reviews under this regulation shall submit a completed application form, including any documentation or information necessary for the commissioner to determine if the independent external review entity satisfies the minimum qualifications established under Section 12 of this regulation.

D.

(1) An approval is effective for two (2) years, unless the commissioner determines before expiration of the approval that the independent external review entity is not satisfying the minimum qualifications established under Section 12 of this regulation.

(2) Whenever the commissioner determines that an independent external review entity no longer satisfies the minimum requirements established under Section 12 of this regulation, the commissioner shall notify the independent external review entity that its approval has been withdrawn and remove the independent external review entity from the list of independent external review entities approved to conduct external reviews under this regulation that is maintained by the commissioner pursuant to subsection E.

E. The commissioner shall maintain and update, as necessary, a list of approved independent external review entities.

F. The commissioner may rely on the accreditation status of an applicant independent external review entity as demonstration of fulfillment of any or all requirements of this section.

Section 12. Minimum Qualifications for Independent External Review Entities

A. To be approved under Section 11 of this regulation to conduct external reviews, an independent external review entity shall meet the requirements of § 10-16-113.5 (4), C.R.S., and shall:

(1) Agree to maintain and provide to the commissioner the information set out in Section 13 of this regulation; and

(2) Submit to the commissioner, with the application for approval as an independent external review entity, a schedule of reasonable fees to be charged to carriers for performance of external review, including administrative fees as described in Section 14.

B. All expert reviewers assigned by an independent external review entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the minimum qualifications and conflict of interest requirements described in § 10-16-113.5(2)(c), C.R.S.

Section 13. External Review Record Requirements

A.

(1) An independent external review entity assigned pursuant to Section 8 or Section 9 of this regulation to conduct an external review shall maintain written records in the aggregate and by carrier on all requests for external review for which it conducted an external review for the Colorado Division of Insurance during a calendar year.

(2) The independent external review entity shall retain the written records required pursuant to this subsection for at least three (3) years.

B.

(1) Each carrier shall maintain written records in the aggregate and for each type (i.e., indemnity, PPO, HMO, and POS) of health coverage plan offered by the carrier on all requests for external review that are filed with the carrier.

(2) The carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Section 14. Funding of External Review

The carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost, consistent with the fee schedule the independent external review entity filed with the commissioner, to the independent external review entity for conducting the external review. In the case of a carrier reversing a denial which is the subject of an external review after assignment of the review to independent external review entity, but prior to assignment of an expert reviewer, the carrier shall pay an administrative fee to the independent external review entity. Charges for the independent external review when denial is reversed by the carrier prior to review completion but after assignment to an expert reviewer, shall be the full cost

Section 15. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of license. Among others, the penalties provided for in § 10-3-1108 and 10-3-1110(2), C.R.S., may be applied.

Section 16. Severability

If any provision of this regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the regulation, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This amended regulation shall be effective on October l, 2003.

Section 18. History

1. Originally promulgated with an effective date of April l, 2000 for the approval process for independent expert review entities and an effective date of June l, 2000 for the external review process.

2. Amended effective October l, 2003 to delete reporting requirements since the Division of Insurance already tracks external review information.

New Regulation 4-2-22 Insurer Assessments for CoverColorado

Section 1 Authority

This regulation is promulgated under the authority of Sections 10-1-109 and 10-8-530(1.5), C.R.S.

Section 2 Background and Purpose

CoverColorado, formerly the Colorado Uninsurable Health Insurance Plan, was created by legislation in 1990 to provide access to health insurance for those Colorado residents who are termed “high risk” because they are unable to obtain health insurance or unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. CoverColorado enrollment has increased and will continue to increase as CoverColorado becomes the state alternative mechanism for federally eligible individuals, as defined in the federal Health Insurance Portability and Accountability Act of 1996 (HPAA). In order to keep up with the rising medical care costs for eligible individuals, § 10-8-530(1.5), C.R.S. was enacted to permit CoverColorado to assess special fees against certain insurers in Colorado, as necessary, to pay projected administrative expenses and losses of the program. Such special fees will be used to supplement premiums and other sources of funding, as set forth in § 10-8-530(1), C.R.S., received by the program.

The purpose of this regulation is to establish the procedures for the assessment of special fees for the CoverColorado program.

Section 3 Definitions

For the purposes of this regulation, the following terms shall have the meanings set forth below:

A. “Benefit design weighted average” means the average actuarial value of the benefits provided under all plans issued in Colorado by the insurer during the previous year, weighted by enrollment in each plan.

B. “CoverColorado” is the Colorado program which provides health insurance for those individuals who are termed “high risk” because they are unable to obtain health insurance or are unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. The program is described in § 10-8-501 et seq. C.R.S.

C. “Eligible Individual” is either:

1. a resident of this state who meets the eligibility requirements set forth in § 10-8-513,C.R.S.;or

2. an individual who meets the eligibility requirements for a federally eligible individual, as set forth in § 10-16-105.5(1), C.R.S. This term does not include the dependents of eligible individuals.

D. “Group health plan” has the same meaning as set forth in § 10-16-105.5(l)(a), C.R.S.

E. “Higher level health benefit plan design” means a health plan benefit design for which the actuarial value of the benefits is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of the benefit design weighted average.

F. “Insurer” is any entity that provides group or individual health benefit plans, as that phrase is defined in §10-16-102(21), C.R.S., and is subject to state insurance regulation in this

state, as well as any entity, including a property and casualty insurance company, that, directly or indirectly, provides stop loss or excess loss insurance to a self-insured group health plan, The phrase “health benefit plans,” as used in this paragraph, shall have the same meaning as set forth in § 10-16-102(21), C.R.S.

G. “Lower level health benefit plan design” means a health benefit plan design for which the actuarial value of the benefits is at least eighty-five percent (85%) but not greater than ninety- nine percent (99%) of the benefit design weighted average.

Section 4 Determination of Need for Special Fee Assessment

A. CoverColorado shall, as frequently as shall be deemed necessary by the CoverColorado board, project (i) the cash balance of the CoverColorado cash fund; (ii) the balance of any funds held or invested by the CoverColorado board or the administering carrier, (iii) interest earned on the CoverColorado funds; (iv) premiums received from the enrolled eligible individuals; (v) revenue from the other sources listed in §10-8-530(1), C.R.S.; (vi) payment for claims incurred by enrolled eligible individuals; (vii) a reserve for claims incurred but not reported for enrolled eligible individuals; (viii) administrative expenses for enrolled eligible individuals; (ix) interest on moneys borrowed to defray the claim costs incurred by enrolled eligible individuals; and (x) a surplus amount equal to ten percent (10%) of projected incurred claims for enrolled eligible individuals. The projections shall not include any costs related to any dependent coverage offered by CoverColorado.

B. To the extent that the projected operating revenues, cash balance and funds then currently held or invested by the program will be adequate to provide for projected claims, administrative expenses and the IBNR reserve and surplus, no assessment shall be made to insurers.

C. To the extent that the projected operating revenues, cash balance and funds then currently held or invested by the program are not adequate, the projected deficiency amount shall be the basis for the determination of a per capita assessment of special fees.

D. The CoverColorado board shall obtain no less than two actuarial evaluations (obtained from qualified actuaries as defined in Division of Insurance Regulation 1-1-1) before undertaking the first assessment and before undertaking any increase in the amount of the assessment in any subsequent year.

Section 5 Determination of Amount of Assessment to Each Insurer

A. Commencing on January 15, 2002 and every March 1 thereafter, each insurer shall report to CoverColorado, on the form prescribed, (i) the total number of employees and retired employees or individual policyholders or subscribers enrolled in all of its health benefit plans offered in this state and (ii) the number of employees/retired employees for whom a premium is paid and coverage is provided under an excess loss, stop loss or reinsurance policy issued by such insurer to an employer or group health plan in this state, as of December 31 of the previous year. The totals to be reported shall not include those employees, retired employees or individual policyholders or subscribers who receive health benefits through Medicare, Medicaid or the Children's Basic Health Plan (pursuant to article 19 of title 26, C.R.S.). CoverColorado shall allow those insurers providing stop loss, excess loss or reinsurance to exclude from then- counts those employees/retired employees or individual policyholders/subscribers who have been counted by the primary carrier or the primary reinsurer.

B. The projected deficiency, if any, determined by CoverColorado in accordance with Section 4.C above shall be assessed in an equitable manner upon insurers, as follows:

1. The projected deficiency shall be divided by the total number of employees, retired employees

and individual policyholders or subscribers reported by all insures, to arrive at a per capita amount.

2. The special fee assessed to each insurer shall be equal to the number of employees and retired employees or individual policyholders or subscribers reported in the month of March immediately preceding issuance of the notice multiplied by the per capita amount.

Section 6 Notice and Collection of the Assessed Special Fees

A. Special fees may be assessed as needed by CoverColorado, but in no event more than twice in any calendar year in accordance with this section. As actual claim and administrative expense information is obtained, it will be incorporated into the succeeding projection.

B. Insurers shall receive written notice of the first per capita assessment, as determined in Section 5.B.1 above, if any, on February 1,2002 and as needed thereafter, subject to section. 6.A above. Each notice of an actual assessment, whether on February 1, 2002 or thereafter, shall include (i) the per capita amount, determined as in Section 5.B.1 above; (ii) a calculation of the assessment due and owing (based on the per capita amount multiplied by the number of employees and retired employees or individual policyholders or subscribers reported in the month of March immediately preceding issuance of the notice); and (iii) a summary o f the projections and underlying assumptions which support the need for the assessment in general and the per capita amount in particular.

C. Insurers shall pay each assessment of special fees to CoverColorado on the first day of the month thirteen (13) months after issuance of the notice of assessment (“the Due Date”) (e.g., the assessment noticed on August 1,2002 will be due and payable on August 1,2003). No later than ninety (90) days before a noticed assessment is due, CoverColorado shall send a general reminder of the assessment Due Date to all insurers.

D. CoverColorado, or its designated agent, shall collect all assessed special fees and deposit the fees into the accounts specifically maintained by the CoverColorado board for this purpose. Any amounts not immediately needed to pay the expenses and losses for eligible individuals shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as part of CoverColorado's plan of operations.

E. If the special fees collected exceed the amount actually needed, the excess shall be invested by the board in accordance with the investment guidelines adopted by the board and filed with the Division of Insurance as a part of CoverColorado's plan of operations and shall, in accordance with Section 4.A. above, be included as funds held by CoverColorado when the next projections are made. Notwithstanding the foregoing, any insurer who has received a deferred status, pursuant to Section 7.A. below, at the time fees are assessed may be entitled to a deferral of the fees, at the discretion of the commissioner.

F. In the event that any insurer fails to pay its special fee as assessed by CoverColorado, CoverColorado shall send one notice of nonpayment thirty (30) days after the Due Date. If CoverColorado has not received payment of all amounts due from an insurer within thirty (30) days after the date of the notice of nonpayment, CoverColorado shall report same to the commissioner.

G. An insurer receiving a certificate of authority to do business in the State of Colorado market on or after the date of issuance by CoverColorado of a notice of assessment shall receive notice of the assessment at the time of licensure and shall be liable for any assessments) due and owing in the calendar year following the year in which the certificate of authority was granted, and thereafter in the normal course of the assessment process. Such new insurer shall not be liable for any assessment due and owing in the calendar year in which the certificate of authority is granted.

H. Any insurer withdrawing from the Colorado market shall only be liable for any assessment owing in the calendar year of withdrawal and shall not be liable for any assessment owing thereafter. The date of withdrawal shall be the date on which the last contract or policy of the insurer in Colorado expires, is terminated by the insurer in accordance with Colorado insurance laws or is voluntarily terminated by the policyholder/subscriber, whichever is sooner. Any insurer discontinuing a type of health coverage (e.g., small group coverage) in the Colorado market shall be liable in the calendar year of discontinuation for any assessment due and owing in that calendar year, and the amount of assessment due and owing shall be calculated pursuant to section 6.B., regardless of any reduction in the number of employees and retired employees or individual policyholders or subscribers in that calendar year by reason of the discontinuation.

Section 7 Deferral of or Credit Against Special Fees

A. Any insurer that believes that the payment of special fees would endanger its financial ability to fulfill its contractual obligations to its insureds may submit, no later than one hundred twenty (120) days before an assessment is due and owing (i.e., 120 days before the Due Date), a written request for deferral of its payment of its assessed special fees to the commissioner, with a copy sent to CoverColorado. The written request for deferral shall be accompanied by certified copies of statutory annual and quarterly statements and any other documents necessary to demonstrate the claimed adverse financial position. Based on the Division of Insurance's risk- based capital guidelines, the commissioner may defer, in whole or in part, payment of the special fees owing on the Due Date in the calendar year in which the request is made. The commissioner's determination regarding deferral shall be made within thirty (30) days of receipt of a written request for deferral, with written notice of the determination sent to CoverColorado. The insurer receiving the deferment shall remain liable to CoverColorado for the defied amount, and the deferred amount shall be incrementally reassessed to the insurer over such period as is deemed reasonable by CoverColorado, in consultation with the commissioner and the insurer, but in no event longer than three (3) years.

B. In the event a special fee assessed against an insurer is deferred, in whole or in par, the amount by which the special fee is deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in Section 5 above (the resulting additional special fees shall be called “excess special fees”). Written notice of excess special fees shall be sent to all insurers no later than sixty (60) days prior to the Due Date. Such excess special fees amount shall be included by the insurer in its payment of previously assessed special fees to CoverColorado on the Due Date. As the deferred assessment is repaid in subsequent assessments by the deferring insurer, as provided in subsection 7.A above, each insurer that paid such excess special fees shall receive a pro rata credit for its share of previously paid excess special fees.

C. An insurer shall be entitled to a credit, in the amount set forth in 7.D below, against special fees assessed (exclusive of excess special fees) if it meets any of the following criteria and has enrolled the required number of individuals in the health benefit plans described during the previous twelve-month period:

1. Any insurer that voluntarily and actively markets and offers, continuously over the twelve-month period preceding the calendar year in which an assessment is due and owing, two different individual health benefit plans to an applicant who has a medical condition on the presumptive conditions list maintained by the CoverColorado board, with the premium for such plans no higher than 125% of the rate charged for a similarly situated (considering age and geographic location) but medically acceptable applicant. The two different plans shall be either.

    a. The two plans that are generally available and actively marketed t3 the public and are the plans with the largest and next to largest premium volume of all individual health benefit plans offered by the insurer in this state; or

b. A lower level health benefit plan design and a higher level benefit plan design, both of which include benefits similar to other individual health benefit plans offered in the state.

2. Any insurer that voluntarily and actively offers, continuously over the twelve- month period preceding the calendar year in which an assessment is due and owing, two different small group health benefit plans to an applicant who is a business group of one under all of the following conditions: (i) outside of the open enrollment periods established by § 10-16-105(7.3)(0, C.R.S.; and (ii) without regard to the health status of the applicant or any dependents. The two different plans shall meet either of the criteria set forth in Paragraphs 7.C.l(a) and (b) above, except that the two plans are those offered by the insurer to small groups, including business groups of one, in Colorado.

3. Any insurer that voluntarily and actively offers, continuously over the twelve- month period preceding the calendar year in which an assessment is due and owing, two different individual conversion health benefit plans to an applicant, (i) without regard to the health status of the applicant; and (ii) at a premium rate that is 10% or more below the CoverColorado rate for a similarly situated individual (considering age, sex, smoking status and geographic location). The two different plans shall meet one of the criteria set forth in Paragraphs 7.C.l(a) and (b) above.

D. Under any of the criteria in Paragraphs 7.C.1, 7.C.2 or 7.C.3 above, the insurer shall be entitled to a credit against any assessment due and owing in a calendar year equal to three percent (3%) for enrolling the following number of individuals in the above-described plans during the preceding twelve-month period:

1. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado (pursuant to Section 5.A above) is 25,000 or less, 25 individuals;

2. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is more than 25,000, but less than 75,000,50 individuals; or

3. If the number of employees/retired employees or individual policyholders/subscribers reported by an insurer on its annual report to CoverColorado is 75,000 or more, 100 individuals.

E. Any insurer that believes that it is entitled to a credit shall submit a written request for credit, along with supporting documentation satisfactory to the commissioner, of compliance with Paragraph 7.C.1, 7.C.2 or 7.C.3 above no later than one hundred twenty (120) days before any assessment is due and owing (i.e., 120 days before any Due Date).

F. The commissioner shall make a determination regarding a credit within sixty (60) days of submission of a written request. All credits will be reported by the commissioner to CoverColorado.

Section 8 Severability

If any provision of this regulation or the application of **it** to any **person or circumstance** is for any reason held to be invalid, the remainder of this regulation shall not **be affected,**

Section 9 Effective Date

This Amended Regulation shall become effective on July 1, 2002.

Section 10 History

New regulation effective on January 1, 2002.

Amended, effective July 1,2002.

New Regulation 4-2-23 Procedure for Provider-Carrier Dispute Resolution

Section 1. Authority

This regulation is promulgated pursuant to §§ 10-1-109,10-3-1110,10-16-109, and 10-16-708, C.R.S.

Section 2. Purpose and Background

The purpose of this regulation is to establish procedures for resolution of provider-earner disputes, as required by § 10-16-705(13), C.R.S.

Section 3. Applicability and Scope

The provisions of tins regulation shall apply to all carriers when they are providing health care services through managed care plans, except workers' compensation and auto insurance contracts.

Section 4. Definitions

A. "Necessary information" consists of the following: 1) each applicable date of service; 2) subscriber or member name; 3) patient name; 4) subscriber or member number; 5) provider name; 6) provider tax identification number, 7) dollar amount in dispute, if applicable; 8) provider position statement explaining the nature of the dispute; and 9) supporting documentation where necessary, e.g., medical records, proof of timely filing.

B "Participating provider" shall have the same definition as m § 10-16-102(28 5), C.R.S and includes any provider that enters into an agreement with a carrier for the provision of a particular health care service or services to a particular insured or insureds

C "Provider-earner dispute" means an administrative, payment or other dispute between a participating provider and a carrier that does not involve a utilization review analysis, but does not include routine provider inquiries that the carrier resolves in a timely fashion through existing informal processes

D "Provider-earner dispute log" means a record of provider dispute resolution requests receive d by the carrier and maintained on a calendar year basis by the carrier At a minimum, the log shall include the date of receipt of the dispute resolution request; the provider's name and tax identification number, the subscriber and patient name, the member number; the date of service, the disputed amount, if applicable, the nature of the dispute, the date the request was closed, whether the request was pended for additional information, and the outcome of the request The suggested

format and additional elements for the log may be set forth by the Division m a bulletin All provider-carrier dispute logs which are produced obtained by or disclosed to the Commissioner shall be given confidential or privileged treatment to the extent provided by law to protect the privacy of the patient and provider Confidential or privileged information may not be made public by the Commissioner, except that access to such materials may be granted to the National Association of Insurance Commissioners (“NAIC”) Disclosure of such materials shall be made only upon the prior written agreement of the NAIC to hold such information confidential or upon the prior written consent of the company to which it pertains

E “Provider representative” means a person designated by a provider m writing, including other providers or an association of providers, to represent the provider's interest during the dispute resolution process

F “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings Techniques include, without limitation, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5. Rules

A. A carrier shall maintain written procedures for provider-earner disputes The procedures shall specify that requests for resolution of provider-carrier disputes must be m writing All written requests for provider-carrier dispute resolution must be-entered into a carrier's provider-carrier dispute log The log shall be made available to the Commissioner within a reasonable time, upon request

B A carrier shall make a determination of a provider dispute resolution request within sixty (60) calendar days of receipt of all necessary information Where the carrier does not receive all necessary information to make a decision, the carrier shall request m writing within thirty (30) calendar days of receipt of the request the additional information needed. The carrier shall allow thirty (30) calendar days from the date of the request to receive the requested information If the provider does not respond within the thirty (30) day timeframe, the carrier shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

C. Notification requirements

1 For provider dispute resolution requests where all necessary information was provided, the carrier shall send written confirmation of receipt within flurry (30) days of the dispute resolution request The written confirmation must contain.

a a description of the carrier's dispute resolution procedures and timeframes,

b the procedures and timeframes for the provider or fee provider's representative to present his rationale for the dispute resolution request; and

c. the date by which the carrier must resolve the dispute resolution request

In the instance where the provider dispute resolution request is resolved in accordance with the requirements of this regulation within thirty (30) days, the notice required by Section 5(E) shall constitute the notice required by this Section 5(C).

2. In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) days of receipt of the provider dispute resolution request, a written notice to the provider that must contain:

a a description of the additional necessary information required to process the request;

b the date that additional information must be provided by the provider, and

c a statement that failuer to provide the requested information within 30 (thirty) calendar days from the carrier's request for additional information will result m the closure of the request with no further review

3 In cases where the provider does not submit the additional necessary information required by the carrier and the carrier closes the request, the carrier shall notify the provider that the case is closed and that further consideration of the closed dispute resolution request must begin with a new request by the provider.

D. A carrier shall offer the provider the opportunity to designate a provider representative m the dispute resolution process. The carrier shall allow the provider or the provider's representative the opportunity to present her rationale for the dispute resolution request m person. In cases where the provider determines that a face-to-face meeting is not practical, the carrier shall offer the provider the opportunity to utilize alternative methods such as teleconference or videoconference to present her rationale for the dispute resolution request The carrier may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process. The parties may mutually agree in writing to extend the timeframes beyond the sixty (60) days from receipt of all necessary information timeframe established by this regulation.

E. A carrier shall provide notification of the determination to me provider. In the event the determination is not in favor of the provider, the written notification shall include the principal reasons for the determination. The written notification shall contain: a) the names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request; b) a statement of the reviewers' understanding of the reason for the provider's dispute; c) the reviewers' decision in clear terms and the rationale for the carrier's decision; and d) a reference to the evidence or documentation used as the basis for the decision.

F. All requirements in this regulation concerning written notification may be met by electronic means, including e-mail or facsimile, as long as confirmation of the transmission can be shown.

G. Nothing in this regulation shall be construed to supercede contract provisions that do not directly conflict with the terms of this regulation. For example, after a final determination is made by the carrier in accordance with the requirements set forth in this regulation, any further consideration of the request shall be handled in accordance with the contract provisions between the carrier and the provider, i.e., the request may be subject to mandatory arbitration as stated in the contract

Section 6. Enforcement

Noncompliance with the requirements and time frames specified in this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of license. Among others, the penalties provided for in §§ 10-3- 1108 and 10-3-1110(2), C.R.S., may be applied. Failure of a carrier to employ the procedures outlined in this regulation constitutes an unfair or deceptive act in the business of insurance under § 10-3-

1104{l)(h)(IV),C.R.S.

Section 7. Severability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8. Effective Date

This regulation is effective on August 1, 2002.

Section 9. History

New regulation, effective August 1, 2002.

New Regulation 4-2-24 Concerning Clean Claim Requirements for Health Carriers

Section 1 Authority

This regulation is promulgated under the authority of 10-16-106.3(2), 10-16-109, and 10-1-109, Colorado Revised Statutes.

Section 2 Background and Purpose

This regulation is being promulgated to meet the requirement of Senate Bill 13, enacted during the 2002 General Assembly, that the Commissioner adopt a uniform list of required elements to be included on specified uniform claim forms in order to be considered a “clean claim.”

Section 3 Applicability and Scope

This regulation applies to any entity that provides health coverage in this state including a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to Article 16 of the insurance laws of Colorado.

Section 4 Rules

A. Clean claims, as defined in Section 10-16-106.5(2), Colorado Revised Statutes, shall be submitted on the appropriate uniform claim form (the American Dental Association Dental Claim Form, the CMS 1500, or the CMS 1450) and include all the required elements as specified in Section 5 of this regulation.

[Note: Formats for standardized forms CMS 1500 and CMS 1450 can be accessed at http://cms.hhs.gov/medicare/edi/edi5.asp. The dental form can be accessed though the American Dental Association.]

B. A carrier shall process clean claims within the time frames specified in statute.

C. A carrier shall pay interest pursuant to Section 10-16-106.5(5), C.R.S., when clean claims are not processed within the specified timeframes.

Section 5 Required Elements

A. The following fields of the American Dental Association Dental Claim Form (2000 version) must be completed before a claim can be considered a "clean claim": (See Attachment I)

i. Field 1, transaction type;

ii. Field 3, carrier name;

iii. Field 4, other coverage;

iv. Fields 5-11, other coverage info (if Field 4 answered "yes");

v. Field 12, subscriber name and address;

vi. Field 15, subscriber identification number;

vii. Field 16, subscriber group number (if group coverage);

viii. Field 18, relationship of patient to subscriber;

ix. Field 20, patient name;

x. Field 21, patient birthdate;

xi. Field 22, patient gender;

xii. Field 24-33, services provided;

xiii. Field 36, information release;

xiv. Field 37, assignment of benefits (required if payment is to be made to provider);

xv. Field 38, place of treatment;

xvi. Field 39, enclosures (if radiographs or models enclosed);

xvii. Field 40, orthodontic treatment;

xviii. Field 45, cause of illness/injury;

xix. Field 48, name and address of billing dentist/entity;

xx. Field 50, dentist license number;

xxi. Field 51, dentist/entity identification number;

xxii. Field 52, dentist/entity phone number; and

xxiii. Field 53, treating dentist signature.

B. The following fields of the CMS 1500 Claim Form must be completed before a claim can be considered a “clean claim”: (see Attachment II)

i. Field 1, type of claim;

ii. Field 1a, insured identification number;

iii. Field 2, patient name;

iv. Field 3, patient birthdate/sex;

v. Field 4, insured name;

vi. Field 5, patient address;

vii. Field 6, relationship of patient to insured;

viii. Field 7, insured address (If same as patient address, can indicate “same”.)

ix. Field 8, patient status (Required only if patient is a dependent);

x. Field 9, other insurance (only if 11d is answered in the affirmative);

xi. Field 10 a,b,c, relation of condition to employment or auto accident;

xii. Field 11, policy number;

xiii. Field 11 c, name of plan;

xiv. Field 11 d, other insurance;

xv. Field 12, information release (“signature on file” is acceptable);

xvi. Field 13, assignment of benefits;

xvii. Field 14, date of onset of illness or condition;

xviii. Field 17, name of referring physician (if applicable);

xix. Field 21, diagnosis;

xx. Field 23, prior authorization number (if any);

xxi. Field 24, A, B, C, D, E, F,G (H,!,J Medicaid only) services and diagnoses;

xxii. Field 25, federal tax ID number

xxiii. Field 28, total charge;

xxiv. Field 31, signature of provider (provider name sufficient);

xxv. Field 32, address of facility where services rendered; and

xxvi. Field 33, provider's billing information.

C. The following fields of the CMS 1450 (UB92) Claim Form must be completed before a claim can be considered a “clean claim”: (see Attachment III)

i. Field 1, provider name, address, telephone number;

ii. Field 3, patient number;

iii. Field 4, type of bill code;

iv. Field 5, provider tax ID number;

v. Field 6, dates of claim period;

vi. Fields 7-10, inpatient hospital days, as appropriate;

vii. Field 12, patient name;

viii. Field 13, patient address;

ix. Field 14, patient date of birth;

x. Field 15, patient sex;

xi. Field 16, marital status;

xii. Field 17, date of admission;

xiii. Field 18, hour of admission;

xiv. Field 19, type of admission;

xv. Field 20, admission source code;

xvi. Field 21, discharge hour (for maternity only);

xvii. Field 22, patient status-at-discharge code;

xviii. Fields 32-36, occurrence information (accidents only);

xix. Field 38, insured address (If same as patient, enter “same”.);

xx. Field 39,40, and 41, value codes and amounts;

xxi. Field 42, revenue code;

xxii. Field 43, revenue description;

xxiii. Field 44, HCPCS/Rates ;

xxiv. Field 45, Service Date (for out-patient services only);

xxv. Field 46, service units;

xxvi. Field 47, total charges;

xxvii. Field 50, payer information;

xxviii. Field 52, information release;

xxix. Field 53, assignment of benefits;

xxx. Field 58, insured name

xxxi. Field 59, relationship of patient to insured;

xxxii. Field 60, patient provider number;

xxxiii. Field 62, group number (only if group coverage);

xxxiv. Field 63, prior authorization number (if any);

xxxv. Fields 64-66, employer information (for Workers comp claims only);

xxxvi. Field 67, principal diagnosis code;

xxxvii. Field 76, admission diagnosis (inpatient only);

xxxviii. Field 79 required only if Fields 80-81 are completed;

xxxix. Fields 80-81, multiple procedures (if applicable);

xl. Field 82, attending physician ID; and

xli. Field 85 and 86, signature and date.

Section 6 Additional Information

A. A claim with all required fields completed is not considered “clean” if additional information is needed in order to adjudicate the claim. Carriers may request additional Information only If the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. When additional information is required, the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form. If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.

B. Additional information requested must be related to information in the required fields of the claim forms, although the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in a required field is incorrect such as previous

claims that indicate the treatment was for work-related injuries when the claim form indicates otherwise. Requests for additional information to determine if the treatment is medically necessary or if a pre-existing condition limitation applies would be related to the fields specifying the services provided.

C. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all required fields correctly completed and the services were preauthorized pursuant to 10-16-704(4), C.R.S.

D. When all additional information or documentation necessary to resolve the claim is provided with the appropriate claim form that includes all required elements as specified in Section 5 of this regulation, the claim shall be considered a clean claim and processed within the timeframes specified in statute. The following circumstances are those for which additional information is generally required by most health carriers:

i. When the coverage is not primary, an EOB from the primary payer;

ii. When service/procedure codes indicate “unusual” procedural services or anesthesia, the medical records to justify medical necessity;

iii. When surgical procedures utilize multiple surgeons, the medical records to justify medical necessity;

iv. When the procedure is a repeat procedure, the medical records to justify medical necessity;

v. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and

vi. When services are billed using a “by report” or unlisted CPT code, medical records to substantiate the claim.

E. If a managed care plan requires medical or other records on all claims for particular types of services/procedures or diagnosis codes, the carrier must clearly disclose such requirements in the provider contract, provider manual, or provider manual updates. If a carrier contracts with an intermediary, the carrier shall be responsible for making sure the intermediary provides such disclosure to contracted providers in a timely manner.

F. When requesting medical records, carriers must identify the particular component(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. Requests for 'all medical records” is not specific enough and would not be an appropriate request for claim adjudication.

Medical information requested from institutional providers shall be additionally limited to the following:

i. History and physical reports;

ii. Consultant reports;

iii. “Op” reports;

iv. Discharge summaries;

v. Emergency department reports;

vi. Diagnostic reports; and

vii. Progress reports.

Section 7 Enforcement

Noncompliance with this regulation may result, after notice and opportunity for hearing, in the imposition of any of the sanctions pertaining to the business of insurance, including the imposition of fines and suspension or revocation of certificate of authority.

Section 8 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 9 Effective Date

This regulation is effective February 1,2003.

Section 10 History

Emergency regulation 02-E-7, effective July 2,2002.

Temporary regulation 02-T-7, effective October 1, 2002.

Regulation 4-2-24 effective February 1,2003.

Attachment I

ADA Dental Claim Form

Attachment I

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   ☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
   ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. Provider ID
50. License Number
51. SSN or TIN
52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) — Date

54. Provider ID
55. License Number
56. Address, City, State, Zip Code
57. Phone Number ( ) –
58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

General Instructions

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope Please fold the form using the tick-marks printed in the left and right margins The upper-right blank space is provided for insertion of the third-party payer's claim or control number

a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow

b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i e, Items 3,11,12,20 and 48)

c) All dates must include the four-digit year (i e, Items 6,13,21,24,36,37,41,44, and 53

d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form Both claim forms are submitted to the third-party payer

Data Element Specific Instructions

1 EPSDT/Title XIX-Mark box if patient is covered by state Medicaid s Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21

2 Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized

4-11 Leave blank if no other coverage

8 The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer

15 The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer

16 Subscriber's or employer group's Plan or Policy Number May also be known as the Certificate Number [Not the subscriber s identification number]

19-23 Complete only if the patient is not the Primary Subscriber (i e, “Self” not checked in Item 18)

19 Check “FTS” if patient is a dependent and full-time student, “PTS” if a part-time student Otherwise, leave blank

23 Enter if dentist's office assigns a unique number to identify the patient that is not the same as the Subscriber Identifier number assigned by the payer (eg, Chart#)

25 Designate tooth number or letter when procedure code directly involves a tooth Use area of the oral cavity code set from ANSI/ADA/ISO Specification No 3950 Designation System for Teeth and Areas of the Oral Cavity'

26 Enter applicable ANSI ASC X12 code list qualifier Use” JP” when designating teeth using the ADA'S Universal/National Tooth Designation System Use “JO” when using the ANSI/ADA/ISO Specification No 3950

27 Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported

28 Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces Enter up to five of the following codes, without spaces B = Buccal, D = Distal, F = Facial, L = Lingual, M = Mesial, and O = Occlusal

29 Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*

31 Dentist's full fee for the dental procedure reported

32 Used when other fees applicable to dental services provided must be recorded Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies

33 Total of all fees listed on the claim form

34 Report missing teeth on each claim submission

35 Use “Remarks” space for additional information such as reports' for 999' codes or multiple supernumerary teeth

36 Patient Signature The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case

37 Subscriber Signature Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider This is an authorization of payment It does not create a contractual relationship between the dentist and the payer

38 ECF is the acronym for Extended Care Facility (eg., nursing home)

48-52 Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber

48 The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information This may differ from the actual treating dentist's name This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist

49 Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN Necessary when assigned by carrier receiving the claim

50 Refers to the license number of the billing dentist This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.

52 The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer When the payment is being accepted directly report the 1) SSN if the billing dentist in unincorporated, 2) Corporation TIN if the billing dentist is incorporated, or 3) Entity TIN when the billing entity is a group practice or clinic

53 The treating, or rendering, dentist s signature and date the claim form was signed Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed

56 Full address, including city, state and zip code, where treatment performed by treating (rendering)

dentist

58 Enter the code that indicates the type of dental professional rendering the service from the Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list The current list is posted at http //www wpc-edi com/codes/codes asp The available taxonomy codes, as of the first printing of this claim form, follow printed in boldface

122300000X Dentist-A dentist is a person qualified by a doctorate in dental surgery (D D S) or dental medicine (D M D) licensed by the state to practice dentistry, and practicing within the scope of that license

Other dentists practice in one of nine specialty areas recognized by the American Dental Association 1223D0001X Dental Public Health 1223P0221X Pediatric Dentistry 1223E0200X Endodontics (Pedodontics) 1223P0106X Oral & Maxillofacial Pathology 1223P0300X Periodontics 1223D0008X Oral and Maxillofacial Radiology 1223P0700X Prosthodontics 1223S0112X Oral & Maxillofacial Surgery 1223X0400X Orthodontics

Many dentists are general practitioners who handle a wide variety of dental needs1223G0001X General Practice

Attachment II

ADA Dental Claim Form

Attachment I

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   ☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
   ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. Provider ID
50. License Number
51. SSN or TIN
52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) — Date

54. Provider ID
55. License Number
56. Address, City, State, Zip Code
57. Phone Number ( ) –
58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties

Refers to Government Programs Only

MEDICARE AND CHAMPUS PAYMENTS A patient s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made See 42 CFR 411.24(a) If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this Is less than the charge submitted CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services Information on the patient's sponsor should be provided in those items captioned in “Insured”, i e, items 1a, 4,6,7,9, and 11

Black Lung and FECA Claims

The provider agrees to accept the amount paid by the Government as payment m full See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

Signature of Physician or Supplier (Medicare, CHAMPUS, FECA AND Black Lung)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as Incident- to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, (3) they must be of kinds commonty furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536) For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424 32)

NOTICE Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws

Notice to Patient About the Collection and Use of Medicare, CHAMPUS, FECA, and Black Lung

Information(Privacy Act Statement)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs Authority to collect information is in section 205(a), 1862,1872 and 1874 of the Social Security Act as amended, 42 CFR 411 24(a) and 424 5(a) (6), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1079 and 1086,5 USC 8101 et.seq, and 30 USC 901 et seq, 38 USC 613, E 0 9397

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For exarnple.itmaycenecessarytodiscloseinfonnationaboutthebenefitsyouhaveusedtoahospital or doctor Additional disclosures are made through routine uses for information contained m systems of records

FOR MEDICARE CLAIMS: See the notice modifying system No 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No 177, page 37549, Wed Sept. 12,1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974 “Reparation of Notice of Systems of Records.” Federal Register Vol 55 No 40,Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13. ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PUPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law

ROUTINE USE(S). Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept of Health and Human Services and/or the Dept of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMP VA: to the Dept. of Justice for representation of the Secretary of defense in civil actions, to the internal Revenue Service claims, and to Congressional Offices m response to Inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS

DISCLOSURES. Voluntary, however, failure to provide information will result m delay in payment or may result in denial of claim With the one exception discussed below, there are no penalties under these programs for refusing to supply information However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs Failure to furnish any other information, such as name or claim number, would delay payment of the claim Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment Section 1128B of the Social Security Act and 31 USC 3801- 3812 provide penalties for withholding this information

You should be aware that P L100-503, the “Computer Matching and Privacy Protection Act of 1988”, permits the government to verify information by way of computer matches

Medicaid Payments (Provider Certification)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept of Health and Humans Services may request

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those clams submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patent and were personally furnished by me or my employee under my personal direction

NOTICE This is to certify that the foregoing information is true accurate and complete I understand that payment and satisfaction of this claim win be from Federal and State funds and that any false claims statements, or documents, or concealment of a material lad, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number The valid OMB control number for this information collection is 0938-0008 The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the Information collection If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, N2-14-26,7500 Security Boulevard, Baltimore Maryland 21244-1850

ADA Dental Claim Form

Attachment I

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   ☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
   ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. Provider ID
50. License Number
51. SSN or TIN
52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) — Date

54. Provider ID
55. License Number
56. Address, City, State, Zip Code
57. Phone Number ( ) –
58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

Uniform Bill: NOTICE:

ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill

1 If third party benefits are indicated as being assigned or in participation status on the face thereof appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in feet no valid assignment of benefits to the hospital was made

2 If patient occupied a private room or required private nursing for medical necessity any required certifications are on file

3 Physician s certifications and re-certifications, if required by contract or Federal regulations, are on file

4 For Christian Science Sanitariums, verifications and if necessary re- verifications of the patients need for sanitarium services are on file

5 Signature of patient or his/her representative on certifications authorization to release information, and payment request as required be Federal law and regulations (42 USC 1935f, 42 CFR 424 36,10 USC1071 thru 1086,32 CFR 199) and, any other applicable contract regulations is on file

6 This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law

7 For Medicare purposes

If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file The patients signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made

8 For Medicaid purposes

This is to certify that the foregoing information is true, accurate, and complete

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws

9 For CHAMPUS purposes

This is to certify that

(a) the information submitted as part of this claim is true, accurate and complete, and the services shown on this form were medically indicated and necessary for the health of the patient,

(b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U S military or U S Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file,

(c) the patient or the patients parent or guardian has responded directly to the providers request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS- determined benefits,

(d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits,

(e) the beneficiary s cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts and

(f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services For purposes of this certification an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty

(g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986 all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1 1987

(h) if CHAMPUS benefits are to be paid in *a* participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider I agree to accept the CHAMPUS- determined reasonable charge as the total charge for the medical services or supplies listed on the claim form I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount if any paid by or on behalf of the patient as full payment for the listed medical services or supplies I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS- determined reasonable charge CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider

Amended Regulation 4-2-25 Pilot Program for Multiple Employer Welfare Arrangements

Section 1. Authority

Section 2. Background And Purpose

Section 1. Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§10-1-109,10-16-109 and 10-16-902(l)(a), C.R.S.

Section 2. Background and Purpose

House Bill 03-1164 created a Pilot Program for the licensure and operation of Multiple Employer Welfare Arrangements (MEWAs). Up to 18 MEWAs can be licensed by the Commissioner. No later than October 15,2007 the Department of Regulatory Agencies must evaluate many factors to determine the Pilot Program's effectiveness. To effectively evaluate the Pilot Program a diverse range of MEWAs should be included. Therefore, licensure decisions will be based on the MEWA meeting financial, contractual and other statutory requirements in addition to considering whether the MEWA is either self-funded or fully insured, type of bona fide association involved, and the Association's service area.

The purpose of this regulation is to establish guidelines for the application process, which will take place prior to October 1, 2003, to ensure an adequate diversity exists for the evaluation of the effectiveness of the Pilot Program, and to set forth the filing requirements and standards for initial and continued licensure of a MEWA under the Pilot Program. Immediate adoption of this regulation is imperatively necessary to comply with state law and compliance with the requirements of the normal procedure for adoption of rules under the State Administrative Procedure Act would be contrary to the public interest.

Section 3. Applications for Approval

A. The Commissioner will accept applications for review for approval as a pilot MEWA until October 1, 2003.

B. If fewer than 18 MEWA pilot applications are approved from the applications received by October 1, 2003, the Commissioner shall designate another time period for accepting additional applications

for consideration.

C. All applications shall document status as a bona fide association pursuant to §10-16-102(5.5), C.R.S., and shall demonstrate the association is either a chamber of commerce, an association of non-profits, a trade association or an association of members of a particular profession.

D. Section 10-16-907(1), C.R.S. prohibits producers from soliciting, advertising or marketing health benefit plans from a MEWA unless the MEWA is authorized by the Commissioner. This does not prohibit an applicant from soliciting input from members to determine interest in a potential plan and assistance in development of the plan, however; no fees, premiums or other funds contributable to a potential plan can be collected nor can any commitment to issue or actual issuance of a health benefit plan occur prior to authorization by the Commissioner.

E. Section 10-16-907(2), C.R.S. prohibits insurers from soliciting or effecting coverage of, underwriting for, collecting charges or premiums for, adjusting or settling claims of a resident of this state, or entering into any agreement to perform any of those functions for a MEWA unless the MEWA is authorized by the Commissioner. This does not prohibit an applicant from soliciting input from members to determine interest in a potential plan and assistance in development of the plan; however, no fees, premiums or other funds contributable to a potential plan can be collected nor can any commitment to issue or actual issuance of a health benefit plan to or on behalf of the MEWA occur prior to authorization by the Commissioner.

F. Only those bona fide associations that accept employers for membership regardless of size, including business groups of one, will be considered for approval.

G. Bona fide associations shall submit the information required by § 10-16-102(5.5), C.R.S., to demonstrate that the association meets all the requirements to qualify as a bona fide association. Additionally, on an annual basis the bona fide association must provide updated information pursuant to §10-16-102(5.5)(f), C.R.S.

Section 4. Application Requirements

A. A folly insured MEWA must submit the following items:

1. A detailed business plan with respect to its current and proposed business operations, and plan as a MEWA. The business plan shall provide sufficient information to verify that the association qualifies as a bona fide association as required in §10-16-102(5.5), C.R.S., along with a description of the planned coverages to be provided, information on deductibles and co-payments if known, and the methods of marketing and enrolling eligible participants.

2. A copy of the sponsor association's organizational documents, membership criteria, ownership, and a summary of the activities and benefits, other than health plan coverage, provided to its membership.

3. A summary of benefits and a confirmation that each plan will be in compliance with the state's requirements for mandated benefits.

4. Application fee required by § 10-16-902 (5)(a), C.R.S.

5. MEWAs providing the name of the insurer providing the coverage at the time of initial application will be given first consideration for approval.

6. Upon approval of a MEWA plan the applicant will be given until December 1, 2003 to provide the name of the insurer providing the coverage. At such time the applicant will also

provide a copy of the products to be offered which shall confirm the information included in the initial filing or the applicant shall provide a detailed explanation of the differences in the final product.

7. Information previously filed by an insurer of a MEWA in compliance with applicable statutes can be referenced and need not be resubmitted. The reference must include the full name of the insurer and the date on which the filing was submitted to the Division of Insurance.

8. Any material modification to the business plan as filed with the commissioner, throughout the authorization period shall be submitted to the commissioner for approval 60 days prior to implementation, except as provided by §10-16-908(2), C.R.S.

B. A self-funded MEWA must submit the following items:

I. A detailed business plan with respect to its current and proposed business operations, as a MEWA. The business plan shall provide sufficient information to verify that the association qualifies as a bona fide association as required in 10-16-102(5.5), C.R.S., its method of marketing and enrolling eligible participants; a description of coverages to be provided, information on deductibles and co-payments; a detailed description of its procedures to provide protection for the consumer (i.e., grievance procedures, peer review, case utilization procedures, etc.); a description of the network in the event of a managed care plan; and an explanation of the techniques to be implemented to ensure continuity of care for all covered persons should the MEWA incur a change in its provider network or financial solvency; the initial and (to the extent practical) renewal rate making methodology, and assumptions; a description of record keeping and identity of those responsible, and a plan for dissolution and record retention when the Pilot Program expires.

2. A copy of the sponsor association's organizational documents, membership criteria, ownership, and a summary of the activities and benefits, other than health plan coverage, provided to its membership.

3. Qualification and experience of the MEWA's senior management.

4. The method of marketing and enrolling eligible participants.

5. A copy of an actuarial opinion complying with the provisions of Colorado Insurance Regulation 3-1-8 (3 CCR 702-3) reflecting the adequacy of the health plan reserves and liabilities reflected in the financial report. This opinion must be expanded to include an analysis of the adequacy of the proposed contribution and funding levels of the health plan.

6. A copy of the underlying actuarial report supporting such opinion, including all methods and assumptions employed.

7. A copy of the agreement demonstrating adequate aggregate excess loss coverage, specific excess loss coverage and insolvency coverage.

8. Information on employer contribution requirements which satisfy the provisions of §10-16-903, C.R.S.

9. A copy of the products offered.

10. Identification, experience and qualifications of individuals to act in a fiduciary capacity as trustees for the plan.

11. Copies of bonds required by §10-16-905(b), C.R.S. for each trustee.

12. Provide the manner in which funds will be held in trust, including location and copies of pertinent agreements.

13. Such other relevant information as the Commissioner may request in order to evaluate the financial condition, actuarial soundness, member benefits and market conduct of the health benefit plan.

14. Application fee required by §10-3-902 (5)(a), C.R.S.

15. Any material modification to the business plan as filed with the commissioner throughout the authorization period shall be submitted to the commissioner for approval 60 days prior to implementation.

Section 5. Financial Requirements

A. A fully insured MEWA under this Pilot Program shall be insured by a carrier licensed to sell health insurance in Colorado and shall be deemed to have met the financial requirements for authorization.

B. A self-funded MEWA shall be considered to have met the financial requirements under the following conditions:

1. Depositing with the Commissioner the minimum amount required by §10-16-902(b)(I), C.R.S., in a manner consistent with §§10-3-206 and 10-3-211, C.R.S.

2. Demonstrating the ability to maintain the minimum funding level as indicated by an actuarial and claims analysis.

3. Maintaining, by the end of the first year of operations and continuously thereafter, assets which exceed liabilities in an amount equal to the greater of either 30% of unpaid claims or 10% of annual claims expense.

4. Plan funds may be invested in cash or securities as allowed for life insurers.

Section 6. Evidence of Coverage

A. Every contractholder/enrollee shall be issued an evidence of coverage or certificate of insurance, which shall contain a clear and complete statement of:

1. The benefits provided;

2. Any limitation of the service, kinds of service or benefits to be provided, and exclusions, including any deductible, co-payment or other charges;

3. Where, and in what manner, information is available as to where and how services may be obtained, and

4. The method for resolving complaints.

B. Any amendment to the evidence of coverage or certificate of insurance shall be provided to all subscribers in a separate document at least thirty (30) days prior to the effective date of the amendment.

Section 7. Complaint System

A. Pursuant to Section 10-3-1104(1) (i), C.R.S., a complaint system shall be maintained by all MEWAs. The complaint system shall include a complaint record which provides at least the minimum information as required in Colorado Insurance Regulation 6-2-1, (3 CCR 702-6).

B. Complaint systems already established by an insurer of a fully insured MEWA can be used to meet these requirements.

Section 8. Requirements of a MEWA Health Benefit Plan

A. Health coverage provided by a MEWA under this Pilot Program shall meet the requirements for health benefit plans as defined in § 10-16-102.

B. A MEWA in the Pilot Program may apply participation requirements to individual employer member groups.

C. Each MEWA shall offer at least the Basic and Standard health benefit plans.

D. AH self-funded MEWA health benefit plans, contracts, policies, and agreements shall be subject to all provisions of Title 10 that apply to health policies, plans, or contracts issued on a group basis.

E. All self-funded MEWA health benefit plans shall state that the plan is being provided by a MEWA. Such plan must clearly be labeled as a "Self-funded Multiple Employer Welfare Arrangement Health Benefit Plan."

F. All self-funded MEWA health benefit plans shall prominently disclose, in large type, in any written agreement, certificate, contract, plan or policy issued by such MEWA the following notice:

"NOTICE"

This health benefit plan is issued by a self-funded Multiple Employer Welfare Arrangement (MEWA). Colorado insurance guaranty funds are not available for this MEWA Health Benefit Plan in the event of an insolvency of this plan.

Section 9. Filing Of Policy Forms, Rates And Charges

A. Policy forms shall be certified in accordance with Section 10-16-107.2, C.R.S., and Colorado Insurance Regulation 1-1-6 (3 CCR 702-1).

B. The rates and charges shall be reasonable in relation to the service provided. No schedule of charges or rates shall be used by a MEWA unless a copy of such schedule of charges or rates, or amendments thereto, has been filed with the Commissioner concurrent with or prior to use. Rate filings are to include a certification by a qualified actuary that the rates are not excessive, inadequate or unfairly discriminatory. Rates and premiums for products issued by a MEWA are to be determined on a fixed prepayment basis. Therefore, no MEWA product may be issued on a cost plus or retrospective rating basis. A MEWA may require co-payments, co-insurance or deductible payments of enrollees as a condition for the receipt of specific health service unless otherwise prohibited by law. Such payments for service shall be shown in the contract as a specified dollar amount or percentage.

C. All employees of member groups shall have the same rate pursuant to §10-16-902(3)(c), C.R.S.

D. MEWAs under this Pilot Program shall file materials intended on being distributed to potential purchasers, i.e., advertising.

E. Policy forms and rates previously filed by an insurer of a fully insured MEWA can be used to meet this requirement.

Section 10. Annual Filings

A. No later than March I of each year, each authorized MEWA shall pay the fees required by §10-16-902(5)(b), C.R.S. and, on a form prescribed by the commissioner, provide necessary information to evaluate the Pilot Program.

B. Trustees, on behalf of a self-funded MEWA fund, shall file a report annually summarizing the financial condition of the fond, itemizing collections from participating employers and detailing all fund expenditures within 30 days from each year end.

C. A self-funded MEWA shall file an annual audit by an independent certified public accountant and shall file the audited financial report with the Commissioner no later than one hundred twenty (120) days following each year-end.

D. A self-funded MEWA shall file an actuarial opinion with the division which states that the reserves and the contribution and funding levels of the arrangement are adequate and which includes the underlying actuarial report in support of the opinion in accordance with the requirements of §10-7-114, C.R.S., and the MEWA shall file such opinion and report within 120 days following each year end.

Section II. Suspension/Revocation Of a MEWA License

A MEWA' s license may be suspended or revoked by the Commissioner for failure to comply with the provisions of this regulation, or with any other applicable state regulations and statutes, or if the Commissioner determines that continued licensure would be detrimental to the covered individuals,

insurance buying public or the general public of this state.

Section 12. Enforcement

In the event that a MEWA ceases to qualify for licensure, it will be transacting the business of insurance in the State of Colorado without a license and subject to the procedures of Parts 9 and 10 of Article 3 of Title 10, C.R.S., and the provisions of the State Administrative Procedure Act, Part 4 of Title 24, C.R.S., as applicable. Any insurer that may have issued a contract to a health plan is not exempt from the liability under its contract solely due to the unauthorized status of a health plan.

Section 13. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 14. Effective Date

This regulation shall be effective April 1, 2004.

Section 15. History

Emergency regulation adopted July 1, 2003.

Hearing September 2, 2003, effective November 1, 2003.

Amended Regulation effective April 1, 2004

Regulation 4-2-26 - Insurer Assessments for Commission on Mandated Health Insurance Benefits

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-109, and 10-16-103.3, C.R.S.

Section 2 Background and Purpose

Senate Bill 68, enacted during the 2003 General Assembly, established a Commission on Mandated Health Insurance Benefits to review existing and proposed mandates for their social and financial impact. The Division of Insurance is required to assess reasonable and necessary fees against insurers for the operation of the Commission. The purpose of this regulation is to specify the procedures for determining the amount of the fees, equitably assessing the fees, and timely collecting the fees.

Section 3 Assessment Determination

A. The Commissioner is required to assess insurers for fees necessary for the operation of the Commission. All licensed entities writing health benefit plans, as defined in § 10-16- 102(21), C.R.S. are subject to assessment under § 10-16-103.3, C.R.S. Any assessment will be allocated equally among those companies who wrote greater than $ 1,000,000 in premium in the combined health markets during the preceding calendar year.

B. In the initial year of operations, the Division anticipates the Commission will conduct eight meetings. The cost associated with these meetings and the portion of .3 FTE allocated to support the Commission are projected to at least equal the $ 20,000.00 maximum assessment provided by § 10-16-103.3(7), C.R.S. Notice of the first assessment shall be provided no later than October 1,2003 and payment for the assessment shall be made no earlier than January 1, 2004,

C. For subsequent years of operation, assessments will be determined after considering the Commission's annual projected income and expenses and any balance or deficit in its account with the State Treasury.

D. The Commissioner will determine the need for an assessment no later than August 1 of each year. Companies will receive an assessment notice prior to October 1 of each year, if an assessment is required.

Section 4 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any sanctions) allowed by law, including, with out limitation, any one or more of the following: civil penalties, fines, license suspension, or license revocation.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Effective Date

This regulation shall become effective on January 1, 2004.

Section 7 History

Emergency regulation effective August 14, 2003.

Emergency regulation effective December 13, 2003.

Effective on January 1, 2004.

Amended Regulation 4-3-1 Minimum Standards For Medicare Supplement Policies

Section 1. Authority

This regulation is promulgated under the authority of Sections 10-1-108 (8), 10-1-109 and Article 18 of Title 10, Colorado Revised Statutes (C.R.S.).

Section 2. Basis and Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and

comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosure in the sale of accident and sickness insurance coverage to persons eligible for Medicare.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 12, 13, 16 and 19, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

(2) All certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organization, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization.

C. Except as specifically provided by statute, Medicare supplement polices are regulated under Section 10-18-101 to 109, C.R.S., and any regulations promulgated thereunder, including this Division of Insurance Regulation 4-3-1. Nothing in this regulation shall be construed as conflicting with statutes that are not specifically applicable to Medicare supplement insurance.

Section 4. Definitions

For the purposes of this regulation:

A. “Applicant” means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificateholder.

B. “Bankruptcy” means when a Medicare+Choice organization, that is not an issuer has filed, or has filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. “Certificate” means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

E. “Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F.

(1) “Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulations; and

(j) A health plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) “Creditable coverage” shall not include one or more, or any combination of, the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof; :

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical sites; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical coverage are secondary or incidental to other insurance benefits.

(3) “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) “ Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

G. “Employee welfare plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. “Insolvency” means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by court of competent jurisdiction in the issuer's state of domicile.

I. “Issuer” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. “Medicare” means “The Health Insurance for the Aged Act,” Title XVIII of the federal “Social Security Act” as amended. This rule does not cover amendments to this statute that were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531).

K. “Medicare+Choice plan” means a plan of coverage for health benefits under Medicare Part C as defined in the definition of Medicare+Choice plan in 42 U.S.C. 1395w-28(b)(1). [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531).], and includes:

(1) Coordinated care plans, which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(3) Medicare+Choice private fee-for-service plans.

L. “Medicare supplement policy” means a group or individual policy of sickness and accident insurance or a subscriber contract of a hospital and medical service association or a health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et. seq.), or an issued policy under a demonstration project, specified in 42 U.S.C. § 1395ss(G)(1), which is advertised, marketed, or designed

primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. This rule does not cover amendments to this statute that were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531.

M. "Nurse" means a "graduate nurse", "practical nurse", "trained practical nurse", "licensed vocational nurse", "licensed practical nurse", "registered nurse" or "registered professional nurse" as defined under Section 12-38-103, C.R.S.

N. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

O. "Secretary" means the Secretary of the United States Department of Health and Human Services.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms that conform to the requirements of this Section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words, which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare Program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare Program.

D. "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisition costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; and

(7) Claims processing costs.

E. “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

F. “Medicare” shall be defined in the policy and certificate. Medicare may be substantially defined as “The Health Insurance for the Aged Act,” Title XVIII of the federal “Social Security Act,” as amended by the Social Security amendments of 1965, and as later amended or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as “The Health Insurance for the Aged Act,” as then constituted and any later amendments or substitutes thereof, or words of similar import. This rule does not cover amendments to this statute that were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531.

G. “Medicare eligible expenses” shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

H. “Physician” shall not be defined more restrictively than as defined in the Medicare Program.

I. “Sickness” shall not be defined to be more restrictive than the following:

“Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted preexisting conditions clauses as described in Section 7A(1) and Section 8 A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. All Medicare supplement insurance policies shall provide for a refund of unearned premium, when the policy is replaced by another Medicare supplement carrier or given a request for cancellation by the insured.

Section 7. Minimum Benefit Standards for Policies or Certificates issued for Delivery Prior to May 1, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits, which are not inconsistent with these standards.

A. General Standards

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "non-cancelable," "guaranteed renewable," or "non-cancelable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)

(a) Except as authorized by the Commissioner of Insurance of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d) of this Section, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy, that provides only such benefits as are required to meet the minimum standards as defined in Section 8 B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificateholder such conversion opportunities as are described in Paragraph (b); or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefits period, if any, or to payment of the maximum benefits.

B. Minimum Benefit Standards

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(4) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days.

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100],

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Minimum Benefit Standards for Policies or Certificates Issued for Delivery on or after September 1, 2003.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after September 1, 2003. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in additional to all other requirements of this regulation:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a -

preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable and

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8 A (5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for such benefits as otherwise meets the requirements of this subsection.

(d) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in Section 8 A (5)(c),or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit

period, if any, or payment of the maximum benefits.

(7) Suspension and reinstitution of Medicare supplement policies shall be in accordance with the following:

(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety days after the date the individual becomes entitled to such assistance.

(b) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act) [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531.]. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of the loss of coverage within 90 days after the date of the loss.

(d) Reinstitution of such coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) Shall provide for classification of premiums on terms at feast as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic (“Core”) Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic “core” package, but not in lieu thereof:

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the Medicare Part A Eligible Expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans “B” through “J” only as provided by Section 9 of this regulation:

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amounts per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the differences between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1, 250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States subject to calendar year deductible of two hundred fifty dollars ($250) and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (b) and patient education to address preventive health care measures.

(b) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Digital rectal examinations;

(ii) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(iii) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(iv) Serum cholesterol screening (every five (5) years);

(v) Thyroid function test;

(vi) Diabetes screening.

(c) Tetanus and Diphtheria booster (every ten (10) years),

(d) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, At-Home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For the purposes of this benefit, the following definitions shall apply:

(i) “Activities of daily living” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self- administered, and changing bandages or other dressings,

(ii) “Care provider” means a duly qualified or licensed home health

aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurse's registry,

(iii) “Home” shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) “At-Home recovery visit” means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a 24-hour period of services provided by a care provider is one (1) visit.

(b) Coverage Requirements and Limitations:

(i) At-Home recovery services provided must be primarily services, which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of At-Home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(aa) No more than the number and type of At-Home recovery visits certified as necessary by the insured's attending physician. The total number of At-Home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(bb) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

(cc) One thousand six hundred dollars ($1,600) per calendar year.

(dd) Seven (7) visits in any one week.

(ee) Care furnished on a visiting basis in the insured's home.

(ff) Services provided by a care provider as defined in this Section.

(gg) At-Home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(hh) At-Home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(11) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, or otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

Section 9. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 8 B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 8 C(11) of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Section 8 B and 8 C and list the benefits in the order shown in this subsection. For the purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in subsection C of this Section, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Standardized Medicare Supplement Benefit Plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 8 B of this regulation.

(2) Standardized Medicare Supplement Benefit Plan "B" shall include only the following: The Basic ("Core") Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible as defined in Section 8 C (1).

(3) Standardized Medicare Supplement Benefit Plan "C" shall include only the following: The Basic ("Core") Benefits as defined in Section 8 B of this regulation, plus the Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8 C (1), (2), (3) and (8) respectively.

(4) Standardized Medicare Supplement Benefit plan "D" shall include only the following: The Basic ("Core") Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in Section 8 C (1), (2), (8) and (10) respectively.

(5) Standardized Medicare Supplement Benefit plan "E" shall include only the following: The Basic ("Core") Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in

a Foreign Country and Preventive Medical Care as defined in Sections 8 C (1), (2), (8) and (9) respectively.

(6) Standardized Medicare Supplement Benefit Plan “F” shall include only the following: The Basic (“Core”) Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8 C (1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible Plan “F” shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan “F” deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 8(C)(1), (2), (3), (5) and (8) respectively. The annual high deductible. Plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “F” policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan “F” deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare Supplement Benefit Plan “G” shall include only the following: The Basic (“Core”) Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Sections 8 C (1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare Supplement Benefit Plan “H” shall consist of only the following: The Basic (“Core”) Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8 C (1), (2), (6) and (8) respectively.

(10) Standardized Medicare Supplement Benefit Plan “I” shall consist of only the following: The Basic (“Core”) Benefits as defined in Section 8 B of this regulation/plus the Medicare Part A Deductible, Skilled Nursing Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 8 C (1), (2), (5), (6), (8) and (10) respectively.

(11) Standardized Medicare Supplement Benefit Plan “J” shall consist of only the following: The Basic (“Core”) Benefits as defined in Section 8 B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventative Medical Care and At-Home Recovery Benefit as defined in Sections 8 C(1), (2), (3), (5), (7), (8), (9) and (10) respectively.

(12) Standardized Medicare supplement benefit high deductible Plan “J” shall consist of only the following: 100% of covered expenses following the payment of annual high deductible Plan “J” deductible. The covered expenses include the core benefit as defined in Section

8(B) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8(C)(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Section 10. Open Enrollment

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection regardless of age.

B. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of that policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant under age sixty-five (65), if;

(1) The application for the policy or certificate is submitted prior to or during the six (6)-month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age, after September 1, 2003; or

(2) The applicant was enrolled for benefits under Medicare Part B without regard to age on or prior to September 1, 2003, and the application for a policy or certificate is submitted during the six (6)-month period beginning with September 1, 2003.

C. Conditions under which benefits may be reduced or excluded:

(1). If the applicant qualifies under either subsection 10(A) or 10(B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under either subsection 10(A) or 10(B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

D. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare

supplement insurance

E. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection 14(C) by either:

(1) Charging a premium rate for persons under age sixty-five (65) that does not exceed the lowest available premium rate for each plan, type, and form level; or

(2) Charging a premium rate for persons under age sixty-five (65) that does not exceed the "credibility-weighted average age premium rate" (C-W AAPR), for each plan, type and form level. The data used to calculate the (C-W AAPR), for each plan, type and form level, is subject to the Colorado credibility requirement (See Section 14(G)). The (C-W AAPR), for each plan, type and form level, is calculated as:

(C-W AAPR) = (<65 CO IP) * (WT <65 CO IP) + (<65 AD IP) * (WT <65 AD IP) + (>65 CO IP) * (WT >65 CO IP) + (>65 AD IP) * (1 - (WT <65 CO IP) - (WT <65 AD IP) - (WT >65 CO IP)),

subject to the following conditions.

(a) (<65 CO IP) or (<65 AD IP) - The indicated premium (IP) for the under age sixty-five (65) insureds is the premium the issuer would charge each of the under age sixty-five (65) insureds using the Colorado data (CO), or acceptable alternative data (AD), for each plan, type or form level. An example of acceptable alternative data is the issuer's national data for the under age sixty-five (65) insureds for each plan, type or form level. While an issuer may use data from the most recent three-year period to enhance credibility, it may not be possible to achieve full credibility for the under age 65 population, (see Section 14(G)), even using the acceptable alternative data, and it may be necessary to supplement this data with the over age 65 indicated premium (see Part (b)).

(b) (>65 CO IP) or (>65 AD IP) - The indicated premium (IP) for the over age sixty-five (65) insureds is the premium the issuer would charge each of the over age sixty-five (65) insureds using the Colorado data (CO), or acceptable alternative data (AD), for each plan, type or form level. It may be necessary to calculate the (>65 CO IP) and the (>65 AD IP) to help meet the Colorado credibility requirement (See Section 14(G)).

(c) (WT <65 CO IP), (WT <65 AD IP) and (WT >65 CO IP) are calculated using the Colorado credibility requirement (see Section 14(G)). These weights (WT), for each plan, type or form level, should be calculated by taking the square root of the quantity (the number of life-years used to calculate each indicated premium, for each plan, type or form level, divided by 2000).

(1) The (WT <65 CO IP), the (WT <65 AD IP), the (WT >65 CO IP), and the (WT >65 AD IP) must each be less than or equal to one, and the ((WT <65CO IP) + the(WT<65AD IP) + the(WT>65 CO IP) + the(WT>65 - AD IP)) must equal one.

(2) If (WT <65 CO IP) =1, then the (WT <65 AD IP) and the (WT>65 CO IP) = 0.

(3) If (WT <65 CO IP) <1, then the (WT <65 AD IP) cannot exceed (1 - (WT <65 CO IP)) and the (WT >65 CO IP) cannot exceed (1 - (WT <65 CO IP) - (WT<65 AD IP)).

(d) Special Cases.

(1) If an issuer has ten or fewer Colorado lives under age 65 currently insured in a given plan, it is acceptable for the issuer to use its national data (NA) and industry data/studies (AD) to calculate the (C-W AAPR), for each plan, type or form level, provided the industry data/studies are: 1) applicable, 2) current, and 3) credible. In this case the (C-W AAPR), for each plan, type or form level, becomes:

(C-W AAPR) = (<65 NA IP) * (WT <65 NA IP) + (<65 AD IP) * (WT <65 AD IP) + (>65 NA IP) * (WT >65 NA IP) + (>65 AD IP) * (1- (WT <65 NA IP) - (WT <65 AD IP) - (WT >65 NA IP)), with the weights as described in part (c) above.

(2) Full data credibility is required to calculate the (C-W AAPR) for each plan, type or form level. If full credibility cannot be achieved using the above methods, an issuer may have to aggregate data over similar policy forms and then calculate the (C-W AAPR), for each plan, type or form level, using the methodology described in (a), (b) and (c) in this subsection. Data aggregation is only permitted in this case and the issuer should use the smallest number of similar forms possible to calculate the (C-W AAPR) for each plan, type or form level. The rate filing should discuss any data aggregation, demonstrate why it was necessary, and discuss how the final premiums were determined for for each plan, type or form level.

F. Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods described in subsection (B) of this section.

G. No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in subsection (B) of this section:

(1) Encouraging of directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care or medical condition of the person; and

(2) Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care or medical condition of the person.

H. No Medicare supplement carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

I. A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale, during the open enrolment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

J. No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the age, health status, claims experience, receipt of health care or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by a producer with the Medicare supplement insurance carrier.

K. Except as provided in subsection (C) of this section and section 22, subsection (A) and (B) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

L. Except as provided in Subsection B and Section 22. Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 11. Guaranteed issue for Eligible Persons

A. Guaranteed Issue

(1) Eligible persons are those individuals described in subsection B who, seek to enroll under the policy during the period specified in Subsection C, arid who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons

An eligible person is an individual described in any of the following examples:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare: and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice organization under Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

(a) The certification of the organization or plan under this part has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the

individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule, For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531.];

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3)

(a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare or cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select Policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 11B(2).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)

(i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization: or

(ii) Of other involuntary termination of coverage or enrollment under the policy:

(b) The issuer of the policy substantially violated a material provision of the policy: or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual:

(5)

(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act {Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and

(b) The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 185 (e) of the federal Social Security Act) [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531.]; or

(6) The individual, upon first becoming eligible for benefits under part A, enrolls in a Medicare+Choice plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

C. Guaranteed Issue Time Periods

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the date the individual receives a notice of termination of cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such termination of cessation) and ends sixty-three (63) days after the date of the applicable notice;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date the individual receives notice of termination and ends sixty three (63) days after the date the applicable coverage terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B{6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the disenrollment and ends on that date that is sixty-three (63) days after the effective date; and

(5) In the case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date

D. Extended Medigap access for interrupted trial periods

(1) In the case of an individual described in Subsection B(5)(or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 11B{6); and

(2) in the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 11B(6); and

(3) For the purposes of Subsection B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Person are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Section 11B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

(2) Section 11 B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection C(1).

(3) Section 11 B(6) shall include any Medicare supplement policy offered by any issuer.

F. Notification provisions

(1) At the time of an event described in subsection B of this Section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subsection B of this Section because of which an individual ceases enrollment under a contract of agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Section 11 A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Section 12. Standards for Claims Payment

A. An insurer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section

4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub, L, No. 100-203) by: [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule. For more detailed information pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531]

(1) Accepting notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on he basis of the information contained in the notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirement set forth in subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 13. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

(1) Lifetime Requirements

(a) Indemnity Forms - A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate forms:

(i) Group Policies - At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or

(ii) Individual Policies - At least sixty-five (65%) percent of the aggregate amount of premiums earned in the case of individual policies,

(b) HMOs - Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) Historical Requirement (Standardized Forms) - All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) comply with the

requirements of part (1) of this Section or provide acceptable justification as to why this historical requirement has not yet been met. If this requirement has not been demonstrated, the rate filing will be disapproved.

(3) Future Period Requirement (Standardized Forms) - All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from part (1) of this Section, or provide acceptable justification as to why this future period requirement has not been met. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc. If this requirement has not been demonstrated, the rate filing will be disapproved.

(4) For purposes of applying subsection A (1) of this Section and subsection C (3) of Section 14 only, group certificates issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be required to comply with the group Medicare Supplement requirements.

(5) Pre-Standardized Plans - For policies issued prior to May 1, 1992, the ratio of incurred claims to earned premiums (loss ratio) shall comply with all of the following requirements. If compliance with these requirements is not demonstrated, the rate filing will be disapproved.

(a) Historical Requirement - All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) is greater than or equal to the originally filled loss ratio for the form(s), or provide acceptable justification as to why this historical requirement has not yet been met;

(b) Historical Requirement Since April 1, 1996 - All filings of rates and rating schedules shall demonstrate that the historical loss ratio since April 1, 1996 meets the appropriate loss ratio requirement from part (1) of this Section as applied to the actual experience beginning with April 1, 1996 to the last date of the experience period;

(c) Future Period Requirement - All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from part (1) of this Section. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc:; and

(d) Lifetime Requirement - All filings of rates and rating schedules shall also demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the originally filed loss ratio for the form(s). All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc.

(6) Rate filings for each plan, type, and form level permitted under subsection 10C for standardized plans marketed after September 1, 2003, must demonstrate compliance with the requirements of subsection 10E. The “weighted average aged premium,” must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph 10E(1)(a).

B. Refund or Credit Calculation

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan..

(2) If, on the basis of the experience as reported, the benchmark ratio since inception {ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare Supplement Benefit Plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this Section, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after April 1, 1996. The first such report shall be due by May 31, 1998 of this amendment.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after the effective date of May 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year, and each subsequent year, loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

(1)

(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filings.

(b) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment, which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall

be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided* by the policy or certificates.

D. Public Hearings

The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of May 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

Section 14. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

C.

(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or producer marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this Section, a “type” means an individual policy or a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D.

(1) Except as provided in Paragraph (1)(a) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state,

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph (a) above shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(b). The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential, which is in the public interest.

E.

(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 13 of this regulation.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

F. Each filing of premium rates is expected to include the following items for each policy form included in the filing. Filings not containing these items may be returned to the filing company as incomplete.

(1) The expected loss ratio by duration for the life of the policy form. These durational expected loss ratios will be evaluated for reasonableness.

(2) Each rate filing shall compare the actual to the expected loss ratio by duration since inception of the policy form. This comparison should: 1) be prepared on a calendar year basis including a row for each duration and a total row including the expected overall loss ratio

for that calendar year; and 2) include a summary comparison over all durations, including the overall expected loss ratio over all durations. This analysis is considered to be most important in the final decision to approve or disapprove a rate increase request.

(3) Each rate filing shall demonstrate that the third year, and each subsequent year, loss ratio, for policies in force for three years or longer, is greater than or equal to the applicable percentage in Section 13A(1)(i) or (ii), or provide acceptable justification as to why this requirement has not yet been met.

(4) Each rate filing is expected to include all required items from Section 5(A) of Colorado Insurance Regulation 4-2-11.

G. The full credibility standard for Medicare supplement policies is 2000 life-years, and 2000 claims, for rating purposes. These standards must be met in a maximum of three years. Any filing which bases its conclusions on data not meeting these standards is considered not fully credible unless the company can justify a lesser standard of full credibility. If the underlying data is not fully credible, for purposes of rate filings only, the filing should aggregate the underlying data according to the following requirements. Once the data has been aggregated, for purposes of rate filings, the data is expected to be aggregated in the same manner for all future rate filings unless further aggregation is necessary to achieve full credibility.

(1) Pre-standardized Forms - If experience for the pre-standardized forms is not fully credible by form, the experience should be combined over all pre-standardized forms. If the combined experience is still not fully credible, the experience must be 1) combined with the experience for similar prestandardized forms marketed by an affiliated company; or 2) combined with experience for the standardized forms.

(2) Standardized Forms - If experience for a standardized form is not fully credible, experience should be: 1) aggregated with the experience of the most similar standardized form(s) to achieve full credibility; or 2) aggregated over all standardized forms. If the experience has been aggregated over all standardized forms to achieve the credibility standard, the indicated increase, following the aggregate analysis, may be allocated over the standardized forms in a manner to be determined by the company, providing that the sum of the proposed increases over all forms, is numerically equal to the indicated amount from the aggregate analysis.

(a) This allows the rate relationships over forms to remain reasonable.

(b) Rate changes for all affected standardized forms should be made concurrently.

(3) Alternative Means - If full credibility cannot be achieved used the above methodology, a weighted average approach should be incorporated in determining a reasonable rate increase. The company should assign the maximum weight possible to the Colorado data and use an acceptable alternative data source for the compliment of this data.

Section 15. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for at least five renewal years.

C. No issuer or other entity shall provide compensation to its producers shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, “compensation” includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders fees.

Section 16. Required Disclosure Provisions

A. General Rules

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits; all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) A Medicare supplement policy or certificate shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Such notice shall include in bold face type the address and telephone number of the Colorado Division of Insurance and a statement that in the event the insurer does not refund the premium within 30 days from the date such refund is requested, the Division of Insurance should be informed accordingly.

(6)

(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare shall provide to those

applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered or not such policies or certificates are advertised, solicited or issued as Medicare supplement policy or certificate as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than the time the policy is delivered.

(b) For the purposes of this Section, "form" means the language, format, size, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement policies or certificates in a format acceptable to the commissioner. Such notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(b) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name.

"NOTICE. Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this Section consists of four parts: cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language

and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and the plans that are offered by, the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The outline of coverage shall include items contained in Appendix B.

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.). [This rule does not cover amendments to this statute which were promulgated later than the effective date of this rule. For more detailed information: pertinent to this statute, please contact the Colorado Division of Insurance at 1560 Broadway, Suite 850, Denver, CO 80202, (303) 894-7531).]; disability income policy; or other policy identified in Section 3.B. of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insured under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

THIS [POLICY, OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection D(1) shall disclose, using the applicable statement in Appendix E, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 17. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace or be in addition to any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.

(4) The benefits and premiums under your Medicare supplement policy can be suspended, if

requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

(5) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force?

(a) If so, with which company?

(b) If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?

(2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a) If so, with which company?

(b) What kind of policy?

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

B. Producers shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. in the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement, of a Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The Notice to Applicant Regarding Replacement of Medicare Supplement Insurance, in Appendix C, required by subsection D above for an issuer, shall be provided in the format prescribed and separately adopted by the Commissioner of Insurance, in no less than twelve(12) point type.

F. Paragraphs 1 and 2, contained in such Notice to the Applicant Regarding Replacement of Medicare Supplement insurance, (applicable to preexisting conditions), in Appendix C, may be deleted by an issuer if the replacement does not involve the application of a new preexisting condition limitation.

Section 18. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television media to the Commissioner of Insurance of this state for review by the commissioner to the extent it may be required under state law. Such advertisement shall comply with all applicable requirements of Division of Insurance Regulation 4-2-3, 3 C.C.R. 702-4 and related guidelines as amended.

Section 19. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer. This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this subsection A.

B. In additional to the practices prohibited in Section 10-3-114 C.R.S., the following acts and practices are prohibited.

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another issuer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

C. The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Section 20. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Section 21. Reporting of Multiple Policies

A. On or before March 1 of each year an issuer shall report to the Division of Insurance, using the Reporting Medicare Supplement Policies Form prescribed and separately adopted by the Commissioner of Insurance, which provides the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate.

(1) Policy and certificate number, and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Section 22. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy for similar benefits to the extent such period had elapsed under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Section 23. Readability Standards

A Medicare supplement policy shall meet the following readability standards:

A. The text must achieve a minimum score of 40 on the Flesch reading ease test;

B. The policy shall be printed, except for specification pages, schedules and tables, in not less than 10 point type, one point leaded;

C. The style, arrangement and overall appearance of the policy shall not give undue prominence to any portion of the text of the policy to any endorsement or riders; and

D. The policy shall contain a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on three (3) or fewer pages of text, or if the policy has more than three (3) pages regardless of the number of words.

For the purposes of this Section, the Flesch reading ease test shall be governed by the provisions of the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act adopted by the NAIC as a Model Act at its January, 1993, meeting.

This rule does not cover amendments to this model act which were promulgated later than the effective date of this rule, January 1, 2001. For more detailed information pertinent to this statute, please contact Rates & Forms Section at 1560 Broadway, Ste 850, Denver, Colorado 80202 (303) 894-7499 or this model act may be examined at any state publications depository library.

Section 24. Medicare Select Policies And Certificates

A.

(1) This Section shall apply to Medicare Select policies and certificates, as defined in this Section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

(1) “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) “Medicare Select issuer” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) “Medicare Select policy” or “Medicare Select certificate” mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

(5) “Network provider” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) “Restricted network provision” means any provision, which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) “Service area” means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subsection I.

(7) Any other information requested by the commissioner.

F.

(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the

changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly,

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection I of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of

coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.

(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home

recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 25. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocations of license.

Section 26. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 27. Effective Date

This amended regulation shall be effective December 1,. 2003.

Section 28. History

1. New regulation 81-1 effective January 1, 1982.

2. Regulation 81-1 repealed and replaced by 89-7.

3. Regulation 89-7 repealed and replaced by 90-4, effective January 1, 1991.

4. Regulation 90-4 repealed and replaced by 91 -18.

5. Regulation 91-18 repealed and replaced by 4-3-1 effective May 1, 1992.

6. Regulation 4-3-1 was amended effective April 1, 1996.

7. Regulation 4-3-1 was amended effective September 1, 1996.

8. Regulation 4-3-1 was amended effective April 1, 1999

9. Regulation 4-3-1 was amended effective January 1, 2001.

10. Regulation 4-3-1 was amended effective September 1, 2003.

11. Sections 10 (E)(2), 27 and 28 were amended effective December 1, 2003

Appendix A

Medicare Supplement Refund Calculation Form For Calendar Year _____

TYPE [1]	SMSBP [2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Completing Exhibit
Title	Telephone Number

Line		(a) Earned Premium [3]	(b) Incurred Claims [4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues [5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		
11.	Adjustment to Incurred Claims for Credibility		
	Ratio 3 = Ratio 2 + Tolerance		

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]Includes Modal Loadings and Fees Charged.
[4]Excludes Active Life Reserves.
[5]This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios".

Appendix A
(continued)

Medicare Supplement Refund Calculation Form For Calendar Year _____

TYPE [1]	SMSBP [2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Completing Exhibit
Title	Telephone Number

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature
Name - Please Type
Title - Please Type
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP PO
FOR CALENDAR YEAR_____

TYPE[1]	SMSBP[2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Completing Exhibit
Title	Telephone Number

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	P L
1		2.770		0.507		0.000		0.000		
2		4.175		0.567		0.000		0.000		
3		4.175		0.567		1.194		0.759		
4		4.175		0.567		2.245		0.771		
5		4.175		0.567		3.170		0.782		
6		4.175		0.567		3.998		0.792		
7		4.175		0.567		4.754		0.802		
8		4.175		0.567		5.445		0.811		
9		4.175		0.567		6.075		0.818		
10		4.175		0.567		6.650		0.824		
11		4.175		0.567		7.176		0.828		
12		4.175		0.567		7.655		0.831		
13		4.175		0.567		8.093		0.834		
14		4.175		0.567		8.493		0.837		
15		4.175		0.567		8.684		0.838		
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, e
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative l
displayed on this worksheet. They are shown here for informational purposes only.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL P
FOR CALENDAR YEAR_____

TYPE[1]	SMSBP[2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Completing Exhibit
Title	Telephone Number

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	P L
1		2.770		0.442		0.000		0.000		
2		4.175		0.493		0.000		0.000		
3		4.175		0.493		1.194		0.659		
4		4.175		0.493		2.245		0.669		
5		4.175		0.493		3.170		0.678		
6		4.175		0.493		3.998		0.686		
7		4.175		0.493		4.754		0.695		
8		4.175		0.493		5.445		0.702		
9		4.175		0.493		6.075		0.708		
10		4.175		0.493		6.650		0.713		
11		4.175		0.493		7.176		0.717		
12		4.175		0.493		7.655		0.720		
13		4.175		0.493		8.093		0.723		
14		4.175		0.493		8.493		0.725		
15		4.175		0.493		8.684		0.725		
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2"SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, e
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumul
displayed on this worksheet. They are shown here for informational purposes only.

APPENDIX B

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____[insert letters of plans being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included
Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department serv
prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insuranc
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				
					Part B Excess (100%)		Part B Excess (80%)		Part B Exces (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limi
				Preventive Care					

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same b
and J after one has paid a calendar year [$1530] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1530
expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B,
include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[For agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[For direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$0	$[840](Part A deductible)
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	$0	Up to $[105] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840](Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	$0	Up to $[105] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment			
First $100 of Medicare Approved Amounts*	100%	$0	$0
Remainder of Medicare Approved Amounts	$0	$0	$100 (Part B deductible)
	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840](Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maxi-mum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[420] a day	$[420] a day $0	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN E

MEDICARE (PART B)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1530] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1530] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $100 of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $100 (Part B. deductible) 20%	 $0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 life-time maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
-Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible) $0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	$0 $0 $0	Actual charges to $40/a visit Up to the number of Medicare-approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
-Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	0%	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN H (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
-Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I (continued)

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1530] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
-Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0***
--Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." "During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $100 (Part B deductible) 20%	 $0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	 $0 $0 $0	 Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (continued)

PARTS A & B (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1530 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS— NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT— NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Appendix C Notice to Applicant Regarding Replacement of Medicare Supplement Insurance

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you

now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy..

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits

- No change in benefits, but lower premiums

- Fewer benefits and lower premiums.

- Other, (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____(Signature of Producer or Other Representative)*[Typed Name and Address of Issuer or Producer]_____(Applicant's Signature)_____(Date)

*Signature not required for direct response sales.

APPENDIX D

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, Annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

Appendix E Disclosure Statements

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

● hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●other approved items and services

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department of state-. senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

●any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●other approved items and services

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

●hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE

DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

●any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

Before You Buy This Insurance

?Check the coverage in **all** health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

●any expenses or services covered by the policy are also covered by Medicare; or

●it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice care

●other approved items & services

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company,

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS
INSURANCE
DUPLICATES SOME
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

●the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

Before You Buy This
Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS Is
NOT MEDICARE
SUPPLEMENT
INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This
Insurance

?Check the coverage in **all** health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

Important Notice to
Persons on Medicare
THIS Is NOT
MEDICARE
SUPPLEMENT
INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This
Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS Is

NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS Is NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this

policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

?Check the coverage in **all** health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance* for *People with Medicare*, available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS Is
NOT MEDICARE
SUPPLEMENT
INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS Is
NOT MEDICARE
SUPPLEMENT
INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice care

●other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be

entitled under Medicare or other insurance.

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE
TO PERSONS ON
MEDICARE THIS Is
NOT MEDICARE
SUPPLEMENT
INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

●hospitalization

●physician services

●hospice

●other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

?Check the coverage in all health insurance policies you already have.

?For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

?For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Amended Regulation 4-4-1 Concerning Requirements for Long-Term Care Insurance

I. Authority

This regulation is promulgated under the authority of § 10-1-109(1), 10-3-110(1) and 10-19- 113.7, Colorado Revised Statutes (C.R.S.).

II. Purpose

The purpose of this regulation is to promote the public interest, and the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care coverage.

III. Applicability and Scope

The requirements of this regulation shall apply to policies delivered or issued for delivery in this state, on or after the effective date hereof.

IV. Definitions

For the purposes of this regulation, the terms “long-term care insurance,” “group long-term care insurance,” “commissioner,” “applicant,” “policy” and “certificate” shall have the meanings set forth in § 10-19-103, C.R.S.

V. Policy Definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. “Activities of daily living” (ADL) means at least bathing, continence, dressing, eating, toileting and transferring.

B. “Acute condition” means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

C. “Bathing” means washing oneself by sponge bath, in either a tub or shower, including the task of getting into or out of the tub or shower.

D. “Cognitive impairment” means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

E. “Continence” means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

F. “Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

G. “Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

H. “Hands on assistance” means any physical assistance without which the individual would not be able to perform the activity of daily living.

I. “Home health care services” means medical and nonmedical services, provided to ill, disabled or infirmed persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

J. “Medicare” shall be defined as the “The Health Insurance for the Aged Act” Title XVIII of the federal “Social Security Act, “as amended by the social security amendments of 1965, and as later amended.

K. “Mental or nervous disorder” shall be defined to include no more than the neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

L. “Skilled nursing care,” “intermediate care,” “personal care,” “home care,” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

M. All providers of services, including but not limited to “skilled nursing facility,” “extended care facility” “intermediate care facility,” “convalescent nursing home,” “personal care facility,” and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

N. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

O. “Transferring” means moving into or out of a bed, chair or wheelchair.

VI. Policy Practices and Provisions

A. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section VII of this regulation.

1. No such policy issued to an individual shall contain renewal provisions less favorable to the insured than “guaranteed renewable.” However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:

   a. That renewal will jeopardize the insurer's solvency; or

   b. That:

      (i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and

      (ii) The policies will continue to experience substantial and unexpected losses over their lifetime; and

      (iii) The projected loss experience of the policies cannot be significantly

improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) The insurer had made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

2. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases.

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease, senile dementia, other organic brain syndromes, or other types of senility diseases;

3. Treatment provided in a government facility (unless otherwise required by law) when there are no charges for services, services for which benefits are available under Medicare or other governmental program (except Medicaid or except as otherwise required by law), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is made normally in the absence of insurance.

4. This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

D. Continuation or Conversion.

1. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of this section, “a basis for continuation of coverage” means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation

benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

3. For the purposes of this section, “a basis for conversion of coverage” means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

4. For the purposes of this section, “converted policy” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy form which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later man thirty-one (31) lays after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

    a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

    b. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

        (i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

        (ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall be included in the converted policy only if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution or marriage.

11. For the purposes of this section: a “Managed-Care Plan” is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

VII. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy contains any conditions or limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any Imitations or conditions for eligibility other than those prohibited under § 10-19-109, C.R.S., Long-term Care Insurance shall set forth a description of such limitations or

conditions, including any required number of clays of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.”

F. Policy Summary. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

3. Any exclusions, reductions and limitations on benefits of long-term care; and

4. If applicable to the policy type, the summary shall also include:

    a. disclosure of the effects of exercising other rights under the policy;

    b. A disclosure of guarantees related to long-term care costs of insurance charges, and

    c. Current and projected maximum lifetime benefits.

G. Accelerated Death Benefit Disclosure for long-term Care. At the time of policy form filing, all life insurers offering an accelerated death benefit for long-term care must file a cost disclosure illustration with the Insurance Division.

1. The cost disclosure illustration shall state separately the charges for the life insurance policy and for the accelerated death benefit for long-term care provision provided for either in the policy or by rider, and the method of application of those charges.

2. In cases where the separately identifiable charge is illustrated as a percentage, the value or policy feature against which the percentage is to be applied must also be disclosed.

3. The cost disclosure illustration shall clearly state whether the accelerated death benefit provision is offered either as a permanent and guaranteed charge or with a guaranteed maximum cost. In the case of policies offering a guaranteed maximum cost, the exact figure of the guaranteed maximum cost shall be clearly and unambiguously disclosed.

    a. At the time of delivery of the outline of coverage, a cost disclosure illustration identical to or substantially similar to that filed with the Insurance Division shall be delivered to a prospective applicant for his review. The cost disclosure illustration must include all the information required to be filed with Division as set out in subsection G(l) and (2) of this section.

VIII. Underwriting Disclosures

A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

1. If an application for long-term insurance contains a question which. asks whether the applicant

has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

B. Except for policies or certificates which are guaranteed issue:

1. The following language shall be set out conspicuously and inclose conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

   Caution: If your answers on this application are incorrect or untrue, [company] may have the right to deny benefits or rescind your policy.

2. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

   Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form][is enclosed][was retained by you when you applied]. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

C. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

D. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Insurance Commissioner in the format prescribed by the Insurance Commissioner.

For more detailed information pertinent to this regulation, please contact the Rates & Forms Section at 1560 Broadway, Ste 850, Denver, Colorado 80202 (303) 894-7499.

IX Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder the option to purchase a policy that provides for benefit levels to increase with the benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. Increases benefit levels annually;

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or

3. Covers a specified percentage of actual or reasonable charges.

B. Where the policy is issued to a group, the required offer in subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in § 10-19- 103(4), C.R.S. other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

C. The offer in subsection A above shall not be required of:

1. Expense incurred long-term care insurance policies.

D. Insurers shall include the following information in or with the outline of coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

X. Requirements for Replacement

A. Questions Concerning Replacement. Individual and direct response solicited long- term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Solicitations Other than Direct Response. Upon determining that a save will involve replacement, an insurer; other than an insurer using direct response solicitations methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the form specified in Appendix A.

C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-ten n care coverage to the applicant upon issuance of the policy. The require notice shall be provided. in the manner specified in Appendix B.

XL Loss Ratio

Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums, provided the expected loss ratio is at least sixty percent and is calculated in a manner which provides for adequate reserving of the long-term care insurance risk. Long-term care benefits provided through the acceleration of the death benefit under a life insurance policy or annuity, where the charge for the acceleration benefit is separately identifiable and where the payment of such long-term care benefits does not result in the decrease of the total amount of benefits payable under the policy (i.e., long-term care

benefits plus balance payable under death), shall be exempt from this section and shall instead be subject to the provision of section VUG. of this Regulation. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

A. Statistical credibility of incurred claims experience and earned premiums;

B. The period for which rates are computed to provide coverage.

C. Experience and projected trends.

D. Concentration of experience within early policy duration;

E. Expected claim fluctuation;

F. Experience refunds, adjustments or dividends;

G. Renewability features;

H. All appropriate expense factors;

I. Interest;

J. Experimental nature of the coverage;

K. Policy reserves;

L. Mix of business by risk classification; and

M. Product features as long elimination periods, high deductibles and high maximum limits.

XII. Requirements to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented together with any application or enrollment form.

XIII. Filing Requirement

Prior to an insurer, non-profit hospital, medical-surgical and health service corporation or health maintenance organization offering group long-term care insurance to a resident of this state pursuant to § 10-19-105, C.R.S., of the Long-term Care Insurance Act, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in Colorado.

In all other instances, insurers, non-profits and health maintenance organizations are required to comply with the appropriate Colorado Insurance Laws and Regulations concerning the filing of forms and rates.

XIV. Standard Format Outline of Coverage

This section of the regulation implements, interprets and makes specific, the provisions of § 10- 19-112, C.R.S., in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage is contained in Appendix C.

XV. Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

1. By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided:

2. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health :are services are covered;

3. By limiting eligible services to services provided by registered nurses or licensed practical nurses.

4. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

5. By requiring that the insured/claimant have an acute condition before home health care services are covered;

6. By limiting benefits to services provided by Medicare-certified agencies or providers.

B. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

C. Insurers offering a home health care benefit in a long-term care policy or certificate will provide for at least 40 home health care visits.

XVI. Standards for Marketing

A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

   "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

5. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with the Subsection A.

6. The insurer shall at solicitation, provide written notice to the prospective policyholder and certificateholder that a senior insurance counseling program approved by the commissioner, is available and the name, address and telephone number of the program.

7. For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms; to Section VI(A)3 of this regulation.

B. In addition to the practices prohibited in § 10-3-1104, C.R.S., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or *in* complete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

XVII. Reporting Requirements

A. Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percent of the agents total sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of i1s producers with the greatest percentages of lapses and replacements as measured by Subsection *A* above.

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the

preceding calendar year.

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies inforce as of the preceding calendar year.

F. For purposes of this section, “policy” shall mean only long-term care insurance and “report” means on a statewide basis.

XVIII. Continuing Education Training

All producers marketing long-term care policies and whose licenses renew on or after January 1, 1998, as a part of their continuing education requirement, shall be required to complete the following training:

A. The training and certification program shall be as follows:

1. Completion of a one time two-hour approved seminar devoted to long-term care policies and receipt of a certificate of completion; or

2. Completion of a one time approved self-study program of long-term care policies equivalent to two hours, upon the completion of which the participant executes a certificate of completion.

B. To qualify, a seminar or self-study program must address the following topics:

1. Basic and Standard Long-term Care Policies

2. Suitability

3. What long-term care policies cover

4. Long-term care services & costs

5. When do benefits begin

6. What is generally not covered

7. Life versus Health Long-term Care Policies

8. Eligibility for Benefits

9. When replacement of a long-term care insurance policy is appropriate

10. Medicare funding limitations for skilled nursing facility care and skilled home care

11. Disabilities which trigger need for long-term care, their frequency, and the impact of age and family caregivers on formal care use.

C. All persons or entities offering or planning to offer a long-term care training and certificate program shall first submit all program materials to the Colorado Division of Insurance for approval.

D. Only certificates issued to or executed by participants in approved seminars or self-study programs will be accepted.

E. All persons required to be trained shall keep in then- records the certificate of completion of the qualified long-term care program.

F. All persons required to be licensed pursuant to Part 2, Article 2 of Title 10, C.R.S., and who engage in the sale or consultation of long-term care policies must file a copy of a certificate of completion of a qualified program with the licensing section of the Colorado Division of Insurance.

G. The two-hour long-term care policy training may be counted toward the twenty-four continuing education requirement of insurance producers.

XIX Standards for Benefit Triggers

A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment

B.

1. Activities of daily living shall include at least five of the following as defined in Section V and in the policy:

   a. Bathing;

   b. Continence;

   c. Dressing;

   d. Eating;

   e. Toileting; and

   f. Transferring;

2. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.

D. For purposes of this section the determination of a deficiency shall not be more restrictive than:

1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

F. Long term care insurance policies shall include a clear description of the process for appealing and

resolving benefit determinations.

G. The requirements set forth in this section shall be effective January 1,1998 and shall apply as follows:

1. Except as provided in Paragraph 1, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

2. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in § 10-19-103(4)(a), C.R.S. that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

XX. Procedures and Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of Cease & Desist Orders, and/or suspensions or revocations of licenses.

XXI. Severability

If any provision of this regulation or application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or enforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

XXII. Effective Date

This regulation shall be effective January 1,1997.

Appendix A Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

According to [your application][information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

(Date)
(Applicant's Signature)

Appendix B Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance policy delivered herewith, issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. [To be included only if the application is attached to the policy.] If after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application may cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

Appendix C

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number of Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form][is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company may have the

right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contact, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a). Pro vide a notice prominently printed on the first page or attached thereto staling: “If for any reason you are dissatisfied with your long-term care policy/certificate you have the right to return it within 30 days and receive a full refund.”

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agent] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long- term care expenses, subject to policy [limitations][waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), wailing periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) (Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending

physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.].

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.)

(d) Exclusions/exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because of the costs of long- term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED

[(a) Describe the policy renewability provisions;

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

(c) Describe waiver of premium provisions or state that there are no such provisions;

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insured clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured]

11. PREMIUM

[(a) State the total annual premium for the policy,

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

Repealed And Repromulgated Regulation 4-4-2 (In Full) limplementation of Basic and Standard Long-Term Care Insurance Plans

Section 1. Authority

This regulation is promulgated pursuant to Sections 10-19-113.7 and 10-1-109, Colorado Revised Statutes (C.R.S.).

Section 2. Statement of Basis and Purpose

The purpose of this insurance Regulation 4-4-2 is to revise the required benefit package, durations of coverage, and terms. The regulation was earlier amended to require the Basic and Standard Long-term Care Insurance Plans to meet federal standards for tax deductibility. This regulation 4-4-2 specifies the

standards for Basic and Standard Long-term Care insurance Plans which every carrier offering, marketing, or selling long-term care insurance coverage to Colorado residents, except those listed in Section 10-19-113.5(l)(b), must actively offer pursuant to Section 10-19-113.5(l)(a) C.R.S. The requirement to offer these plans does not preclude the marketing of other long-term care insurance products.

Pursuant to Section 10-19-113.7 C.R.S. the Commissioner is to adopt the rules necessary to implement the Basic Long-term Care Plan and Standard Long-term Care Plan effective January 1, 1997. In addition to this regulation, the Basic Long-term Care Plan and Standard Long-term Care Plan shall also comply with applicable standards and requirements contained in Colorado laws and other regulations.

The Basic Long-term Care Plan is defined as suitable for sale to persons with moderate incomes. The Standard Long-term Care Plan is defined as suitable for sale to persons with middle or high incomes.

This regulation outlines the benefits, benefit, levels, marketing standards, and other requirements for the sale of the Basic Long-term Care Plan and Standard Long-term Care Plan. Section 10-19- 113.5(2)(c) C.R.S. establishes an annual review of the packages and recommendations for changes in the plans.

Section 3. Definitions

No Basic Long-term Care Plan or Standard Long-term Care Plan delivered or issued for delivery in this state shall use the terms set forth below unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. “Activities of daily living” (ADL) means bathing, continence, dressing, eating, toileting and transferring.

B. “Bathing,” means washing oneself by sponge bath, in either a tub or shower, including the task of getting into or out of the tub or shower.

C. “Chronically ill individual,” for the purposes of this regulation means any individual who has been certified by a licensed health care practitioner as: being unable to perform without substantial assistance from another individual at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

1. “Substantial assistance” means hands-on assistance and standby assistance.

(a) “Hands-on assistance” means the physical assistance of another person without which the individual would be unable to perform the ADL.

(b) “Standby assistance” means the presence of another person within arm's reach of the chronically ill individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

2. “Substantial supervision” means continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety.

D. “Cognitive impairment” means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

E. “Continence” means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

F. “Dressing,” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

G. “Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

H. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

I. “Transferring,” means moving into or out of a bed, chair or wheelchair.

Section 4. Rules

A. With respect to group long-term care insurance as defined in Section 10-19-103(4), C.R.S., the required offer of a choice of the Basic Long-term Care Plan and Standard Long-term Care Plan may be satisfied by making the offer to the group long-term care insurance policyholder. If membership in a group or association is marketed or sold by carriers and producers, or if carriers or producers distribute or accept membership applications, the group or association does not qualify under Section 10-19-103(4), C.R.S., and the requirement to offer a choice of the Basic Long-term Care Plan and Standard Long-term Care Plan must also be made to each member of such a group or association.

B. A carrier shall actively market the Basic Long-term Care Plan and Standard Long-term Care Plan, using at least the same sources and methods of distribution that it routinely uses; in Colorado to market its most frequently sold long-term care insurance plan.

C. Carriers and producers selling long-term care insurance shall present the Basic and Standard Long-term Care Plans to each person solicited for long-term care insurance. With respect to group long-term care insurance, if the group policyholder rejects the offer of the Basic and Standard Long-term Care Insurance Plans, then mailings to members of the group need not include information on the Basic and Standard Long-term Care Plans. With respect to all other types of long-term care insurance, for direct mail business the Basic and Standard Long-term Care Plans must be included in all offerings.

Carriers and producers shall make reasonable efforts to obtain the signature of each applicant for long-term care insurance on a statement certifying that the applicant has been provided information about the Basic Long-term Care Plan and Standard Long-term Care Plan and an explanation of these plans' benefits and costs. If application for the Basic Long-term Care Plan or Standard Long-term Care Plan is made directly with the carrier by mail or other method, the carrier's obligation under this subsection shall be satisfied if the carrier includes in the application materials a statement to be signed and returned to the carrier pursuant to this subsection.

D. The Basic and Standard Long-term Care Plans shall be identified as specified below.

1. Each carrier shall title and market the Basic Long-term Care Plan as follows: “[Carrier name] Basic Long-term Care Insurance Plan for Colorado.”

2. Each carrier shall title and market the Standard Long-term Care Plan as follows: “[Carrier name] Standard Long-term Care Insurance Plan for Colorado.”

E. The Basic and Standard Long-term Care Plans shall include the specified benefits and coverages

outlined in this regulation. There shall be no variations in the benefits, payment levels, duration, terms or other requirements as specified in this regulation.

1. The form and level of coverage specified in this regulation may be expanded to add increased coverage, such as additional service settings, longer benefit duration, and higher payment levels, through a rider or endorsement at the option of the policyholder only. Marketing materials, carriers and producers must clearly differentiate the Basic and Standard Long-term Care Insurance Benefit Plans from the benefits and costs that may be added by rider.

2. Under no circumstances shall the mandatory provisions of the Basic and Standard Long-term Care Plans be lessened by rider, endorsement or otherwise at the time of sale except for alternative methods of inflation protection or waiver of inflation protection coverage. Consumers may, at their sole discretion, reduce coverage amounts beginning 180 days after the date of purchase.

F. Both the Basic and Standard Long-term Care Plans shall contain provisions sufficient to quality the purchaser of the plan to receive any tax deduction available under 26 U.S. C. § 7702B as amended by section 321 of the Health Insurance Portability and Accountability Act of 1996, Pub. L No. 104-191, signed into law on August 21,1996.

Section 5. Benefit Terms Applicable to Both the Basic Long-Term Care Plan and Standard Long-Term Care

A. Elimination Period. Under the Basic and Standard Long-term Care Plans, the elimination period, during which no benefits shall be paid, shall be for sixty (60) days and may be imposed only once during the lifetime of the policy. Satisfaction of the elimination period begins with the first day on which benefit eligibility is established and, except as provided in subparagraph 2, expenses are incurred for which payment would be made if mere were no elimination period. Only days on which services are used are credited toward satisfaction of the elimination period.

1. There is no elimination period for chronically ill individuals receiving caregiver training benefits or supportive equipment benefits.

2. Insurance contracts that make payments on a per diem or other periodic basis without regard to the actual expenses incurred or services used shall not be required 1:0 establish which day's eligible expenses are incurred or services used.

B. Inflation Protection.

1. The Basic and Standard Long-term Care Plans shall contain an inflation protection provision which increases the previous year's daily maximum benefit and unused plan benefit by five percent (5%) on each anniversary starting with the second policy year and continuing for the life of the policy. The increasing benefits, except as provided in subparagraph 2, shall apply even when the policy is in claim status. Annual increases shall apply to benefits payable for any expenses incurred on or after the date of the increase.

2. Applicants may reject the inflation protection provision, or may opt for an alternative method of inflation protection. The rejection shall be apart of the application and shall state:

   “I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed [insert Basic or Standard Long-term Care Plan as appropriate] and I reject inflation protection.”

C. Benefit Payments. After satisfaction of the elimination period when required, the Basic and Standard Long-term Care Plans shall pay the actual charges for benefits up to the applicable maximum daily benefit, except as allowed in section V. A. (2).

D. Benefit Triggers. The Basic and Standard Long-term Care Plans shall condition the payment of benefits on a determination that the insured is a chronically ill individual as defined in section 3, subsection C. ADL triggers shall be satisfied by the need for standby assistance. The individual applying for benefits must be certified as chronically ill by a licensed health care practitioner.

1. The Basic Long-term Care Plan and Standard Long-term Care Plan shall include a clear description of the process for appealing and resolving benefit determination disputes.

2. All benefit triggers shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.”

E. Waiver of Premium. Premium payments for the Basic and Standard Long-term Care Plans shall be waived once the insured has been eligible for benefits and receiving care in a nursing home or alternate care facility, including the elimination period, for ninety (90) consecutive days or on the 91st day that benefits for home care services or adult day care become payable, including the elimination period. Premiums shall again become due when benefits are no longer received for a period of 30 days.

F. Other Applicable Laws and Regulations. The Basic Long-term Care Plan and Standard Long- term Care Plan shall also comply with applicable standards and requirements contained in Colorado law and other regulations.

G. The Basic and Standard Long-Term Care Plans shall provide benefits for nursing home, residential care facilities, home care services, adult day care, respite care, hospice care, home modification and supportive equipment, caregiver training, case management, and bed reservation needed due to temporary hospitalization.

H. Nursing home benefits in the Basic and Standard Long-term Care Plans shall be payable for qualified skilled, intermediate, or custodial levels of care in an institution that is duly state licensed to provide care and services sufficient to support nursing home inpatient needs resulting from inability to perform ADLs or cognitive impairment

I. Residential care facility benefits are payable for qualified intermediate and custodial levels of care provided in state licensed facilities to support needs resulting from the inability to perform ADLs or cognitive impairment

J. Home care services mean medical and nonmedical services provided to ill, disabled or infirm persons in the home. Such services shall include nursing services, physical, occupational, respiratory, and speech therapy services, homemaker services, assistance with activities of daily living, personal care services, and adult day care services.

1. Medically-based Home Care Services must be provided by a state licensed or certified home health care agency, or directly by an individual who is state licensed or certified to provide such services.

2. Non-medical Home Care Services must be provided by state licensed or certified agencies, or agencies that are accredited by recognized national accreditation organizations, or directly by an individual who is licensed or certified to provide such services. This individual must be monitored by a state licensed nurse or state licensed or registered social worker and included as a provider in the plan of care.

K. Adult Day Care Benefits shall be payable for facilities licensed or state certified to provide adult day care, and for other day care programs that are:

1. Non-residential facilities providing 6 to 12 hours of care per day,

2. Maintains a written plan of care for each client and monitors participants daily to assure the plan of care is carried out;

3. Provides assistance with activities of daily living; and

4. Has a client-to-staff ratio of at least 1 staff member for every 8 clients.

L. Respite Care Benefit. Benefits shall be payable for chronically ill individuals at home for respite care services provided in the home, in a nursing facility, or in a residential care facility. Benefits up to the daily benefit maximum shall be payable for a maximum of 21 days per calendar year.

M. Hospice Care Benefit. Hospice care services may be provided by skilled or unskilled persons through a home health care agency or community hospice organization.

N. Home Modifications and Supportive Equipment Benefit Payment for appropriate home modifications and supportive equipment shall be covered benefits. Home modification and supportive equipment benefits shall be paid for the rental, lease, purchase and installation of supportive equipment mat is used to provide covered long-term care services. This benefit shall be payable for at least a lifetime maximum of fifty times the daily maximum benefit This benefit shall not be used to satisfy the lifetime elimination period, and the insured need not complete the elimination period before this benefit is paid.

O. Caregiver Training Benefit. Caregiver training benefits shall be paid for chronically ill individuals at home if a designated person, agreed to by the carrier, requires training in the proper use and care of supportive equipment, medical aids, assistance with activities of daily living or other supportive needs of the insured. The total caregiver training benefit shall be five times the daily maximum benefit. This benefit shall not be used to satisfy the lifetime elimination period, and the insured need not complete the elimination period before this benefit is paid. This benefit shall not pay for informal care provided by the caregiver.

P. Case management services shall be payable for chronically ill individuals at home. The insured may choose to receive case management services from an independent agency or an agency affiliated with the insurer. The consultation fee shall be paid, in addition to other benefits that are being received, up to at least four times the daily maximum benefit each year. This benefit shall not be used to satisfy the lifetime elimination period, and the insured need not complete the elimination period before this benefit is paid. The plans of care developed by both insurer-designated agencies and agencies not affiliated with the insurer are advisory only.

Q. Bed Reservation Benefit. If a temporary hospitalization is required during a period of confinement in a nursing home and the elimination period has been met, the Basic and Standard Long-term Care Plans shall pay any charge to reserve accommodations in the nursing home facility up to the daily maximum benefit The policy shall pay bed reservation benefits for up to twenty-one (21) days of hospitalization during a policy year. If a temporary hospitalization is required during a period of confinement in a nursing home and the elimination period has not been met, then each day the insured is hospitalized shall count toward the elimination period.

R. Alternate Plan of Care. Chronically ill individuals may receive appropriate long-term care services that are not specifically mentioned in the policy if the insured, the insured's doctor, and the carrier agree to such care.

Section 6. Maximum Benefit Amounts

A. The Standard Long-term Care Plan shall have a maximum benefit amount of $192,000 at issue. The Basic Long-term Care Plan shall have a maximum benefit amount of $115,000 at issue. These maximum benefit amounts constitute a single pool of money available to be paid out for all covered care settings. Except for inflation protection as provided for in paragraph B, in no event shall the total benefits paid under this policy exceed the maximum benefit amount. Only the actual benefit paid, up to the daily maximum benefit, shall be applied to the maximum benefit amount

B. The daily maximum benefit shall be $110 per day at issue for nursing home, alternate care facility, home care, adult day care, respite care, hospice, and bed reservation benefits. If inflation protection is in effect then, over time, it shall effectively increase the lifetime maximum benefit amount and the maximum daily rate according to the terms and Conditions of the policy.

Section 7. Reporting Requirements

A. Any carrier newly entering the long-term care insurance market in Colorado shall provide a policy form and rate information for each duration of the benefit package, and marketing materials related to the policy form prior to marketing to Colorado residents.

B. After making the initial filings described in subsection A, long-term care insurance carriers shall follow the same requirements for subsequent filings and reports for the Basic and Standard Long-term Care Plans as apply to all other long-term care insurance products.

Section 8. Procedures and Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of penalties, issuance of cease and desist orders, and/or suspensions or revocations of license.

Section 9. Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

Section 10. Effective Date

This amended regulation is effective August 1,2001. Current long-term care insurers must comply with regulation 4-4-2 and appropriate Colorado Insurance Laws and Regulations concerning the filing of forms and rates no later than February 1,2002.

History:

1. Original regulation effective July 1,1996

2. Emergency regulation 96-E-4 requires plans qualify for federal tax deductibility effective October 9,1996

3. Amended 4-4-2 adopting emergency regulation as permanent and making minor changes to sections III and V effective February 1,1997

4. Repealed and re promulgated with revised benefit packages and terms, effective August

1,2001. Existing long- term care insurers must certify compliance with the reenacted regulation no later than February 1, 2002.

Regulation 4-4-3 Suitability Standards for Long-Term Care Insurance Products

I. Authority

This regulation is promulgated pursuant to Sections 10-1-109 and 10-19-113.7, Colorado Revised Statutes (C.R.S.).

II. Basis and Purpose

The purpose of this regulation is to establish standards for carriers and producers to determine whether the purchase or replacement of a long-term care insurance product is appropriate for the financial needs of the applicant. This regulation shall not apply to life insurance policies that accelerate benefits for long-term care.

III. Rules

A. Every insurer, carrier, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

1. Develop and, effective January 1,1997, use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2. Train its producers in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

B.

1. To determine whether the applicant meets the standards developed by the issuer, the issuer shall develop and the issuer and producer effective January 1,1997 shall use procedures that take the following into consideration:

   a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

   b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

   c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2. The issuer and, where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix A, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be maintained on file by the carrier for three (3) years and made available for inspection

upon request by the commissioner.

3. Effective January 1,1997, a completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix A is prohibited.

C. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

D. Effective January 1,1997, producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

E. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance” shall be provided. The form shall be in the format contained in Appendix B, in not less than twelve (12) point type.

F. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. If rejected, the issuer shall send the applicant a letter substantially similar to Appendix C. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

G. The issuer shall maintain an annual report of the total aggregate number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. These reports shall be kept on file for three years, and made available for inspection upon request by the commissioner.

IV. Reporting Requirements

All licensed long-term care insurance carriers shall file their initial suitability standards with the Division by November 1,1996.

V. Procedures and Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of penalties, issuance of cease and desist orders, and/or suspensions or revocations of license.

VI. Severability

If any provision of this regulation or the application thereof to any person or circumstance is held invalid or unenforceable by a court of competent jurisdiction, such invalidity or unenforceability shall not affect the other provisions, and this regulation is expressly declared to be severable.

VII. Effective Date

This regulation is effective October 1,1996.

Suitability standards must be used effective January 1,1997.

Appendix A Long Term Care Insurance Personal Worksheet

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

The premium for the coverage you are considering will be [$_____per month, or $_____ per year], [a one-time single premium of $_____.]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in[year], when premiums went up by an average of____%]. [The company has not raised its rates for this policy.]

Drafting note: The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it shall disclose the company's rate increases under prior policies providing essentially similar coverage.

?Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

Drafting Note: The issuer shall use the bracket sentence unless the policy is fully paid up or is a noncancellable policy.

Income

Where will you get the money to pay each year's premiums?

?Income ?Savings ?Family members

What is your annual income? (check one)

?Under $10,000 ?$[10-20,000] ?$[20-30,000] ?$[30-50,000] ?Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

?No change ?Increase ?Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

?Under $20,000 ?$20,000-$30,000 ?$30,000-$50,000 ?Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

?Stay about the same ?Increase ?Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

? The information provided above accurately describes my financial situation.	? I choose not to complete this information.

Signed:

(Applicant) (Date)

?I explained to the applicant the importance of completing this information.

Signed:

(Producer) (Date)

Producer's Printed Name: _____.]

[Note: In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed:

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or producer sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Appendix B Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- ([You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

(Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- Colorado requires carriers selling long-term care insurance to offer a “Basic Long-term Care Plan” and a “Standard Long-term Care Plan” with standardized benefits to make it easier to compare policies among the various companies.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You should not buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local County Department of Social Services or the Medicare counseling program at the Colorado Division of Insurance, phone 303-894-7499.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the long-term care shopper's guide approved by the Colorado Commissioner of Insurance. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through the Medicare counseling program at the Colorado Division of Insurance, phone 303-894-7499.

Appendix C Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklist “Shopper's Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

? Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

? No. I have decided not to buy a policy at this time.

_____ _____

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

Amended Regulation 4-6-2 Group Coordination of Benefits

Section 1. Authority

Section 2. Background and Purpose

Section 3. Applicability and Scope

Section 4. Definitions

Section 5. Model COB Contract Provisions

Section 6. Rules for Coordination of Benefits

Section 7. Procedure to be Followed by Secondary Plan

Section 8. Notice to Covered Persons

Section 1. Authority

This regulation is promulgated under the authority of §§10-1-109 and 10-16-109, C.R.S.

Section 2. Background and Purpose

The purpose of this regulation is to:

A. Permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law;

B. Establish a uniform order-of-benefit determination under which plans pay claims;

C. Provide authority for the orderly transfer of necessary information and funds between plans;

D. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first;

E. Reduce claims payment delays; and

F. Require that COB provisions be consistent with this regulation.

Section 3. Applicability and Scope

This regulation shall apply to all group health coverage plans issued by carriers licensed to do business in Colorado under Article 14, 16 and 19 of Title 10, C.R.S.

Section 4. Definitions

As used in this regulation, these words and terms have the following meanings:

A. "Allowable expense" means a health care service or expense including deductibles, coinsurance or copayments, that is covered in foil or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

(1) The following are examples of expenses or services that are not an allowable expense:

(a) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice or one of the plans routinely provides coverage for private hospital rooms) is not an allowable expense.

(b) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense.

(c) If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

(2) The definition of “allowable expense” may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of “allowable expense” shall include similar services or expenses to which COB applies.

(3) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(4) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan, because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.

(5) If the primary plan is a closed panel plan with no out-of-network benefits and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as it were primary when no benefits are available from the primary plan because the covered person uses a non-panel provider, except for emergency services that are paid or provided by the primary.

(6) If the two plans are closed panels:

(a) The two plans will coordinate benefits for services that are covered services for both plans, including emergency services, authorized referrals, or services from providers that are participating in both plans.

(b) COB does not occur if there is no covered benefit from either plan. This may occur in various circumstances including, if the enrollee did not go to either plan's closed panel of providers, unless there is a covered benefit (i.e. medical emergency, authorized out of network referral, etc).

(c) If the enrollee obtains services that are covered benefits of the primary plan, the secondary carrier shall coordinate benefits only to the extent that there are benefits or reserves available.

(d) If the service is not a covered benefit of the primary plan but the service is a covered benefit of the secondary plan (i.e. the Covered Person went to a provider who does not participate with the primary plan and the service is not due to a medical emergency), (i.e., the Covered Person went to a provider who does not participate with the primary plan the services is not due to a medical emergency), the secondary plan will pay benefits as though they are primary.

B. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(1) Services (including supplies);

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of Paragraphs (1) and (2) above; or

(4) An indemnification.

C. "Claim determination period" means a period of not less than twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

(1) The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

(2) As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

D. "Closed panel plan" means a health maintenance organization (HMO), preferred provider organization (PPO) or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel provider.

E. "Coordination of benefits" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

F. "Custodial parent" means the parent awarded sole custody of a child by a court decree. In the absence of a court decree awarding sole custody, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation is the custodial parent.

G. "Hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

H. "Plan" means a form of coverage with which coordination is allowed or required. The definition of plan in the group contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one

plan and there is no COB among the separate parts of the plan.

(1) The definition shown in the model COB provision in Appendix A is an example but any definition that satisfies this subsection may be used.

(2) This regulation uses the term “plan.” However, a contract may use “program” or some other term that meets the definition of a plan.

(3) Plan may include:

(a) Group insurance contracts and group subscriber contracts;

(b) Uninsured arrangements of group or group-type coverage;

(c) Group or group-type coverage through closed panel plans;

(d) Group-type contracts. Group-type contracts are contracts, which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage;

(e) The amount by which group or group-type hospital indemnity benefits exceed $200 per day;

(f) The medical care components of .group long-term care contracts, such as skilled nursing care;

(g) The medical benefits coverage in group, group-type and individual automobile “no fault” and traditional automobile “fault” type contracts; and

(h) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(i) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) Plan shall not include:

(a) Individual or family insurance contracts;

(b) Individual or family subscriber contracts;

(c) Individual or family coverage through closed panel plans;

(d) Individual or family coverage under other prepayment, group practice and individual practice plans;

(e) Group or group-type hospital indemnity benefits of $200 per day or less;

(f) School accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis;

(g) Benefits provided in group long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the

receipt of services;

(h) Medicare supplement policies;

(i) A state plan under Medicaid; or

(j) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

I. “Primary plan” means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true:

(1) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

(2) All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

J. “Secondary plan” means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

K. “This plan” means, in a COB provision, the part of the group contract providing the health care benefits to which the GOB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar benefits, and may apply another COB provision to coordinate with other benefits.

Section 5. Use of Model COB Contract Provision

A. Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of Subsections B, C and D below and to the provisions of Section 6.

B. Appendix B is a plain language description of the COB process that explains to the covered person how carriers will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (or more) plans will pay for or provide benefits, how the benefit reserve is accrued and how the covered person may use the benefit reserve.

C. The COB provision (Appendix A) and the plain language explanation (Appendix B) do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(1) Another plan exists and the covered person did not enroll in that plan;

(2) A person is or could have been covered under another plan, except with respect to Part B of

Medicare; or

(3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are “always excess” or “always secondary” except in accord with the rules permitted by this regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider, with the exceptions of medical emergencies and if there are allowable benefits available. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan must use the benefit reserve to pay any unpaid allowable expense. See Section 4.A. (6).

Section 6. Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

D. Order-of-Benefit Determination

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary.

(d) If the parents are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents[1] spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial parent; and then

(iv) The plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse who as an active worker will be determined under Subsection D(l). Also, see Appendix A.

(4) Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law and also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for

the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(b) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Section 7. Procedure to be Followed by Secondary Plan

A.

(1) When a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the secondary plan must:

(a) Determine its obligation, pursuant to its contract;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claim determination period.

(2) If there is a benefit reserve, the secondary plan shall use the covered person's recorded benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not

a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall, be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

(1) When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

(2) The requirements of Paragraph B(l) do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 8. Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: “If you are covered by more than one health benefit plan, you should file all your claims with each plan.”

Section 9. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B.

(1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (noncomplying plan) on the following basis:

(a) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(c) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

(2) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law, allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

(3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the

complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

Section 10. Effective Date For Existing Contracts

A. This regulation is applicable to every group contract that provides health care benefits and that is issued on or after the effective date of this regulation.

B. A group contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

(1) The next anniversary date or renewal date of the group contract; or

(2) The expiration of any applicable collectively-bargained contract pursuant to which it was written.

Section 11. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado Statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocations of license.

Section 12. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 13. Effective Date

A. This regulation is applicable to all health coverage plans that are issued on or after February 1,2004.

Section 14. History

Regulation 78-6, was effective March 1, 1972.

Regulation 78-6, was amended and reenacted July 1,1979.

Regulation 78-6, was amended effective May 15, 1986.

Regulation 78-6 was repealed and replaced by Regulation 4-6-2, effective July 1, 1993.

Regulation 4-6-2 was repealed and repromulgated effective July 1, 2002.

Sections 2, 4(3)(g), 13 and 14 amended effective February 1,2004.

Appendix A Model COB Contract Provisions Coordination of This Group Contract's Benefits with Other Benefits

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. “Plan” is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Definitions

A. A “plan” is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) “Plan” includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

(2) “Plan” does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. The order of benefit determination rules determine whether this plan is a “primary plan” or “secondary plan” when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

C. “Allowable expense” means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(1) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.

(2) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and

customary fees for a specific benefit is not an allowable expense.

(3) If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.

(5) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions and precertification of admissions.

D. “Claim determination period” is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

E. “Closed panel plan” is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. “Custodial parent” means a parent awarded custody by a court decree. In the absence, of a court decree,-it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of .a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a

dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

(c) If the parents are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

(3) Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(I).

(4) Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(6) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. Li

addition, this plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(1) Determine its obligation to pay or provide benefits under its contract;

(2) Determine whether a benefit reserve has been recorded for the covered person; and

(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a covered person is enrolled in two or more closed panel plans the following coordination of benefits rules will apply:

(1) COB does not occur if the enrollee did not go to either plan's closed panel, unless there is a covered benefit (i.e. medical emergency, etc.).

(2) The two plans will coordinate benefits for covered services that are covered services for both plans (i.e. emergency services, services from providers that are participating in both plans, etc.).

(3) If the covered person goes to the primary plan's closed panel providers for covered services, the secondary carrier shall coordinate benefits only to the extent that there are benefits or reserves available.

(4) If the primary closed panel has no liability because the covered person did not use the closed panel providers, but the covered person used the secondary closed panel providers, the secondary plan will pay benefits as though they are primary.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Appendix B Consumer Explanatory Booklet Coordination of Benefits

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when;

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

● The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

● The claim is for the health care expenses of a child covered by this plan and

● your birthday is earlier in the year than your spouse's. This is known as the “birthday rule”;

or

● you are not married and you have informed us of a court decree that makes you responsible for the child's health care expenses;

or

● there is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An “allowable expense” is a health care service or expense covered by one of the plans, including copayments and deductibles.

● If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.

● We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

● If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.

● We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Benefit Reserve

When we are secondary we often will pay less than we would have paid if we had been primary. Each

time we “save” by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve.

● We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings.

● To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans.

● Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions About Coordination of Benefits?Colorado Division of Insurance1560 Broadway, Ste 850Denver, CO 80202 Phone Number: 303-894-7490 or 1-800-930-3745

Amended Regulation 4-6-3 Concerning CoverColorado Standardized Notice Form And Eligibility Requirements

Section 1. Authority

This regulation is promulgated by the Commissioner of Insurance under the authority of §§ 10-1 -109 and 10-8-520, C.R.S. “

Section 2. Basis and Purpose

The purpose of this amended regulation is to specify standardized notice requirements to be used to notify individuals of their eligibility for CoverColorado.

Section 3. Applicability and Scope

This regulation applies to all carriers offering health benefit plans to residents of Colorado.

Section 4. Rules

A. Definitions

1. “Carrier” means an insurance company, non-profit hospital, medical-surgical and health service corporation, health maintenance organization or fraternal benefit society, which is authorized by the Commissioner to transact health insurance in Colorado.

2. “Federally eligible individual” shall have the same meaning as defined in Colorado Revised Statute 10-16-105.5(1).

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

1. In order to comply with § 10-8-521, C.R.S., all carriers giving notice to an applicant or insured of one or more of the following adverse underwriting determinations shall be required to give notice to the applicant or insured that he or she may be eligible for coverage under CoverColorado. Dependents of participants are also eligible for coverage under the program. The adverse underwriting decisions which require the carrier to notify the applicant/insured are:

    a. The applicant is rejected for insurance because of the medical condition or history of the applicant; or

    b. The application was accepted, but the premium rate for insurance exceeds the rate available through CoverColorado; or

    c. Coverage will be reduced, limited by a restrictive rider or by the exclusion of coverage for a pre-existing condition for longer than six months.

2. Carriers shall be required to complete the CoverColorado Notice Form for every adverse underwriting determination listed above. Carriers may print the CoverColorado Notice Form on their own stationery but shall use the order, format and content of the CoverColorado Notice Form, as prescribed by the Commissioner of Insurance.

3. The carrier shall attach a copy of the CoverColorado Program Notice Form to the notice of adverse underwriting determination sent to an applicant for insurance. The carrier shall attach a copy of the Notice Form to a copy of the policy and endorsement when it is sent to the insured in the case of an individual being accepted for health insurance coverage but at a premium rate exceeding the rate available through the CoverColorado Program.

4. Insurers should inform individuals they may be eligible for participation in the plan, without first requiring application to a carrier for health coverage, if a licensed physician has diagnosed the individual with a medical condition that is on the list of presumptive medical conditions established by the CoverColorado Board of Directors.

C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions

The elements of notification as determined by the Commissioner, which must be given to individuals with adverse underwriting decisions are:

Applicant/Insureds:

1. Name.

2. Policy number (if applicable).

3. Reasons for notice: rejection of coverage, health rate higher than the rate available through Cover-Colorado or coverage that will be reduced by a restrictive rider or by excluding coverage for a pre-existing condition longer than six months or involuntarily terminated for reasons other than nonpayment of premium.

4. That the individual and dependents are eligible for the health care coverage through CoverColorado.

5. Name, address, contact person, and telephone number of CoverColorado Administrative Office to which interested persons should be referred.

6. Name and telephone number of underwriter or other contact at the carrier's office.

7. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

D. Notification Requirements for Federally Eligible Individuals

1. Individuals who meet the definition of a federally eligible individual under 10-16-105.5, C.R.S., are automatically eligible for CoverColorado. A dependent of a federally eligible individual shall also be eligible for coverage under CoverColorado if the dependent satisfies the definition of "dependent" under § 10-16-102(14) C.R.S.

2.

a. When a termination of coverage results in a federally eligible individual, the group carrier shall provide notice to the individual as specified in paragraph E. Notice, to the extent practicable, shall be provided at a time consistent with notice required for certification of creditable coverage.

b. When an individual carrier receives an application for coverage from a federally eligible individual, the individual carrier shall provide notice to the individual as specified in paragraph E.

E. Elements of the CoverColorado Notice Form for Federally Eligible Individuals

The elements of notification as determined by the Commissioner, which must be given to federally eligible individuals:

Applicant/Insureds:

1. Name.

2. Policy number (if applicable).

3. Notice that-the individual and dependents if applicable, may qualify for health insurance from CoverColorado, as a federally eligible individual.

4. Name, address, contact person, and telephone number of CoverColorado Administrative Office to which interested persons should be referred.

5. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

Section 5. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 6. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision shall not

be affected thereby.

Section 7. Effective Date

This regulation shall become effective on February 1,2002.

Section 8. History

1. New Regulation 91-3 effective April 1,1991.

2. Regulation 91-3 was renumbered 4-6-3, effective June 1,1992.

3. Amended effective April 1, 1994.

4. Amended effective November 1,1997.

5. Amended effective September 1,2000.

6. Emergency Regulation 01-E-I, effective January 1,2002.

7. Amended effective February 1, 2002.

Amended Regulation 4-6-5 Implementation of Basic and Standard Health Benefit Plans

1. Authority

This regulation is promulgated pursuant to §§ 10-1-109,10-16-105(7.2), 10-16-108.5(8), and 10- 16-109, C.R.S.

2. Purpose

The purpose of this amendment to 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 changes required by new and existing state laws pertaining to health coverages. The standard health benefit plan is intended to reflect average level of coverage offered in the small group market and the basic health benefit plan is intended to reflect the lowest level of coverage offered in the small group market. In addition, pursuant to Section 10-16-105(7.2)(b)(I), C.R.S., the basic plan does not include the

following mandated benefits: low-dose mammography; mental illness (except for biologically-based mental illness); hospice care and home health services; alcoholism; prostate screening; and anesthesia and hospitalization for dental procedures for children. This regualtion 4-6-5 specifies the requirements for the implementation of the basic and standard health benefit plans.

3. Rules

A.

1. 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.

Basic Plan. The form and content of the basic health benefit plan, as appended to this regulation, shall constitute the basic health benefit plan design pursuant to §10-16-105 (7.2), C.R.S., and shall be required for use in Colorado's small group market pursuant to Section 10-16-105(7.3), C.R.S. and as conversion coverage pursuant to Section 10-16-108, C.R.S. In addition to offering this plan basic plan design, a small group carrier may offer options pursuant to §10-16-105(7.2)(b)(II), 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 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.

1. The following disclosure statement, prominently displayed in bold type 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 Regulation 4-2-20), small employer application forms, and small employer renewal notices, and on all written refusals to insure which 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. For purposes of this regulation, “clear and conspicuous” means that a disclosure is reasonably understandable and designed to call attention to the nature and significance of the information in the disclosure. 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. Uses a type size that is the same or greater than the type size predominantly used in the communication;

    c. Provides wide margins and ample line spacing;

    d. Uses boldface, capitals or italics for key words; and

    e. In a form that combines the disclosure with other information, uses a plain- language heading to call attention to the notice or uses distinctive type size, style, and graphic devices, such as shading or sidebars.

3. Disclosures on web sites. 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 § 10-8-601.5(3), C.R.S., a small employer carrier shall offer the basic and standard health benefit plans along with all 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.

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. 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.

2. 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.

3. 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.

H.

1. 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:

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

   b. A price quote 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 the open enrollment period. In the case of a sample price quote, the small employer carrier may 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

   c. Information describing how the business group of one can enroll in such plans.

   The explanation shall be provided within the time frames provided in Paragraph G. Indirectly to the business group of one or through an authorized producer.

2. 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).

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 renew ability requirements specified in § 10- 16-201.5, C.R.S..

L.

1. 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- 8-601.5(1), C.R.S.

2. If a small employer carrier fails to comply with Paragraph L.I., the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with Paragraph L.1.

M.

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;

e. The total number of individuals, separated as to employees and dependents, insured under basic and standard health benefit plans and reinsured pursuant to 10-8-605, C.R.S.; and

f. 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.

4. 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 insurance licenses.

5. 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.

6. Effective Date

This amended regulation is effective on January 1, 2004.

7. 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.

Standard and Basic Health Benefit Plan Policy Requirements for the State of ColoradoColorado Division of Insurance

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

II. 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."

III. 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.

IV. 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.

V. 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 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- 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 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** - The maximum employer contribution required by the carrier shall be no more than fifty percent (50%) of the premium for employee-only coverage. The carrier shall not impose a maximum or minimum employer contribution for dependent coverage. Employers, at their discretion, may choose to make a contribution on behalf of dependents and may choose to pay more than fifty percent of the premium for employee coverage.

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 standard and basic 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.[1]

[1]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 groin; health. plan in Colorado.

H. **Out-of-pocket Maximum** - All cost sharing (deductibles, co-insurance, co-pays), unless specifically noted otherwise, apply toward the annual out-of-pocket maximum. After out-of-pocket maximum is satisfied, benefit is paid at 100%.

I. **Primary Care Providers** - Health plans may use non-physician providers, such as registered nurses and physician assistants, as primary care providers under the basic and standard health benefit plans. However, plans are not mandated to include non-physician providers.

[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 CompaniesName of Carrier2004 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMOName 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 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

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC H
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETW (out-of-net not covere not
4. ANNUAL DEDUCTIBLE			(Deductibles are separate from in-network deductibles)	
a) Individual	$ 1,000	$ 750	$ 1,500	No deductibl
b) Family	$ 3,000	$ 2,250	$ 4,500	No deductibl

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC H
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETW (out-of-net not covere no
5. OUT-OF-POCKET ANNUAL MAXIMUM[2] a) Individual b) Family	 $3,500 $8,000	 $3,750 excluding flat dollar copays $8,250 excluding flat dollar copays	 $ 6,500 $14,500	 $ 3,000 $ 6,000[3]
5A. COINSURANCE (amount paid by carrier) or COPAY a) Individual b) Family	 50% of 1st $5,000 100% thereafter 50% of 1st $10,000 100% thereafter	 70% of 1st $10,000 100% thereafter 70% of 1st $20,000 100% thereafter	 50% of 1st $10,000 100% thereafter 50% of 1st $20,000 100% thereafter	 [Depends or see details b
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$1 million	$1 million		No lifetime r
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 cover varies by HM
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 varie
8. ROUTINE MEDICAL OFFICE VISITS[5]	50%	70%, except that if plan uses gatekeepers, $20 copay per gatekeeper visit.	50%	$20 copay/vi
9. PREVENTIVE CARE (deductible does not apply)[6]	[For all plans, only specified preventive services are covered.]			
a) Children's services b) Adults' services	$10 copay/visit. $10 copay/visit.	$10 copay/visit. $10 copay/visit.	50% 50%	$10 copay/vi $10 copay/vi

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC H
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETW (out-of-net not covere no
10. MATERNITY a) Prenatal b) Delivery & inpatient well baby care [7]	50% (deductible does not apply) 50%	70% (deductible does not apply) 70%	50% (deductible does not apply) 50%	$20/office vi for procedur ordered by p $850 copay admission [8]
11. PRESCRIPTION DRUGS [9] Level of coverage & restrictions on prescriptions.	50%	50%	50%	$20 copay p generic; $35 copay p brand name $50 copay n [9a]
12. INPATIENT HOSPITAL	50%	70%	50%	$850 copay admission [10]
13. OUTPATIENT/AMBULATORY SURGERY	50%	70%	50%	$150 copay/
14. LABORATORY & X-RAY [11]	50%	70%. If services are delivered as part of an office visit to an individual's designated primary care provider, then there is no additional copay or coinsurance requirement for lab & x-ray services.	50%	$20 copay / services are as part of an to an individu designated p provider, the additional co coinsurance for lab & x-ra
15. EMERGENCY CARE [12] [13]	50%	70%	70%	$200 copay/ (including em transport) for of-network em care.
16. AMBULANCE	50%	70%	70%	$200 copay/t (including em room care) fo out-of-networ emergency ca

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC H
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETW (out-of-net not covere no
17. URGENT, NON-ROUTINE AFTER HOURS CARE	50%	70%	50%	$50 copay/ network urg covered onl temporarily area.
18. BIOLOGICALLY-BASED MENTAL ILLNESS [15] CARE	For all plans, coverage is no less extensive than the coverage for any other physical that plan.			
19. OTHER MENTAL HEALTH CARE [17] a) Inpatient care[16] b) Outpatient care	50%, Maximum 45 inpatient or 90 partial days/year 50%, Plan/insurer pays maximum $1,000/year	50%, Maximum 45 inpatient or 90 partial days per year 50%, Plan/insurer pays maximum $1,000/year		50%, Maxim inpatient or days per yea 50%, Plans maximum 20 $1,000/year
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered 50%.[18]	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered 50%.[18]		Diagnosis, n treatment & services. Co 50%.[19]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	50%	70%	50%	$20 per visit
22. DURABLE MEDICAL EQUIPMENT [21]	50% up to maximum $800/year paid by plan.	50% up to maximum $800/year paid by plan.		50% up to m $800/year pa
23. OXYGEN	[Included under durable medical equipment]	[Included under durable medical equipment]		[Included un medical equi
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancr bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neu lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. stem cell support is a covered benefit for the same conditions as listed above for bone transplants.			
	50%	70%	50%	Coverage is extensive tha coverage for physical illne
25. HOME HEALTH CARE	50%	70%	50%	$20 copay/vi

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC H
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETW (out-of-net not covere no
26. HOSPICE CARE [22a.]	50% per diem	70% per diem	50% per diem	$50 copay i diem $20 copay H per diem
27. SKILLED NURSING FACILITY CARE [23]	50% [Not to exceed 100 days/year]	70% [Not to exceed 100 days/year]	50% [Not to exceed 100 days/year]	$50 copay/c exceed 100
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an acci			
29. VISION CARE	No coverage	No coverage	No coverage	No coverage
30. CHIROPRACTIC CARE	No [See 31(2)]	No [See 31(2)]	No [See 31(2)]	No [See 31
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)				
(1) TMJ with a medical basis	50%	70%	50%	Applicable c type of servi
(2) Spinal manipulation	50%	70%	50%	$20 copay

Part C: Limitations and Exclusions

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN	
		IN-NETWORK	OUT-OF-NETWOR
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [20,21]	Business Groups of One: 12 months for all pre-existing conditions Business Gro of 2 - 50: 6 months for all pre-existing conditions		
33. EXCLUSIONARY RIDERSCan an individual's specific, pre-existing condition be entirely excluded, from the. policy?	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 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 ado child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.		

35.	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Standard exclusions, including benefits covered by a no-fault auto policy or 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 with no medical basis; 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; and war.

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for your 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 (i.e., go in-network) than if you don't (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 "Out-of-pocket Maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or co-payments, depending on the contract for that plan. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. Under the basic plan, co-pays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

3 However, neither the Individual nor the family out-of-pocket HMO annual maximum may exceed 200% of the annual premium, if federally qualified.

4 However, notwithstanding the copay amounts listed In this 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 out-patient psychotherapy visits for biologically-based mental Illnesses.

6 See Attachment 1 for list of covered preventive services.

7 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

8 The hospital copay applies to mother and well-baby together; there are no 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.

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.

11 Includes diagnostic low dose mammography (Routine mammography screenings not covered). 12 "Emergency care" means services delivered by an emergency care facility which 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 by the carrier or their primary care physician to the emergency room for care. If emergency rooms are used by the plan for non-emergency after hours care, then urgent care co-pays 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

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 in *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 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.

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. CompaniesName of Carrier2004 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY. PREFERRED PROVIDER. AND HMOName 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 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

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDA
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NET (out-of- not cov
4. ANNUAL DEDUCTIBLE			(Deductibles are separate from in-network deductibles)	
a) Individual	$ 500	$ 300	$ 600	No deduc
b) Family	$1,500	$ 900	$1,800	No deduc
5. OUT-OF-POCKET ANNUAL MAXIMUM [2]				
a) Individual	$2,000	$1,500 excluding flat dollar co-pays	$ 5,600	$2,000[3]
b) Family	$4,500	$3,300 excluding flat dollar co-pays	$11,800	$4,500 [3]

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDA
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NE (out-of- not cov
5A. COINSURANCE (amount paid by carrier) or COPAY a) Individual b) Family	70% of 1st $5,000 100% thereafter 70% of 1st $10,000 100% thereafter	80% of 1st $6,000 100% thereafter 80% of 1st $12,000 100% thereafter	50% of 1st $10,000 100% thereafter 50% of 1st $20,000 100% thereafter	[Depends see detai
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$1 million	$1 million		No lifetim
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 co varies by
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 v
8. ROUTINE MEDICAL OFFICE VISITS[5]	70%	80%, except that if plan uses gatekeepers, $15 copay per gatekeeper visit.	50%	$15 copa
9. PREVENTIVE CARE (deductible does not apply)[6]	[For all plans, only specified preventive services are covered.]			
a) Children's services b) Adults' services	$10 copay/visit. $10 copay/visit.	$10 copay/visit. $10 copay/visit.	50% 50%	$10 copa $10 copa
10. MATERNITY a) Prenatal	70% (deductible does not apply)	80% (deductible does not apply)	50% (deductible does not apply)	$15/office for proced ordered b
b) Delivery & inpatient well baby care[7]	70%	80%	50%	$100 copa admission
11. PRESCRIPTION DRUGS[9] Level of coverage & restrictions on prescriptions.	50%	50%	50%	$10 copay generic; $20 copay brand nam $35 copay preferred[9]

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDA
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NE (out-of- not cov
12. **INPATIENT HOSPITAL**	70%	80%	50%	$100 co admissio
13. **OUTPATIENT/AMBULATORY SURGERY**	70%	80%	50%	$50 copa
14. **LABORATORY & X-RAY** [11]	70%	80%. If services are delivered as part of an office visit to an individual's designated primary care provider, then there is no additional copay or coinsurance requirement for lab & x-ray services.	50%	No copa ordered
15. **EMERGENCY CARE** [12 13]	70%	80%	80%	$50 copa (includin transpor of-netwo care.
16. **AMBULANCE**	70%	80%	80%	$50 copa (includin room ca out-of-ne emerger
17. **URGENT, NON-ROUTINE AFTER HOURS CARE**	70%	80%	50%	$25 copa network covered temporar of servic
18. **BIOLOGICALLY-BASED MENTAL ILLNESS** [15] **CARE**	For all plans, coverage is no less extensive than the coverage for any other physi that plan.			
19. **OTHER MENTAL HEALTH CARE**[17]				
a) **Inpatient care**[16]	50%, Maximum 45 inpatient or 90 partial days/year	50%, Maximum 45 inpatient or 90 partial days per year		50%, Ma inpatient days per
b) **Outpatient care**	50%, Plan/insurer pays maximum $1,500/year	50%, Plan/insurer pays maximum $1,500/year		50%, Pla maximun $1,500/y

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDA
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NE (out-of- not cov
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime covered 50%.[18]	Acute detox: maximum 5 days per episode and 2 episodes per lifetime covered 50%.[18]		Diagnos treatmer services 50%.[19]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	70%	80%	50%	$15 per
22. DURABLE MEDICAL EQUIPMENT [21]	50% up to maximum $800/year paid by plan.	50% up to maximum $800/year paid by plan.		50% up t $800/yea
23. OXYGEN	[Included under durable medical equipment]	[Included under durable medical equipment]		[Included medical
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/p bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome o stem cell support is a covered benefit for the same conditions as listed above for bo transplants.			
	70%	80%	50%	Coverag extensive coverage physical
25. HOME HEALTH CARE	70%	80%	50%	No copay covered)
26. HOSPICE CARE [22a]	70% per diem	80% per diem	50% per diem	No copay covered)
27. SKILLED NURSING FACILITY CARE[23]	70% [Not to exceed 100 days/year]	80% [Not to exceed 100 days/year]	50% [Not to exceed 100 days/year]	$50 copa exceed 1
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an a			
29. VISION CARE	No coverage	No coverage	No coverage	No cover
30. CHIROPRACTIC CARE	No [See 31(2)]	No [See 31(2)]	No [See 31(2)]	No [See

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDA
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NET (out-of-n not cove
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)				
(1) TMJ with a medical basis	70%	80%	50%	Applicable type of se
(2) Spinal manipulation	70%	80%	50%	$15 copay

PART C: LIMITATIONS AND EXCLUSIONS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [24] [25]	6 months for all pre-existing conditions			Not applicable; not impose limits periods for pre 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; not exclude c pre-existing c

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD
		IN-NETWORK	OUT-OF-NETWORK	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by a no-fault auto policy or employers l care that is not medically necessary; cosmetic care; custodial care; dental care except t and anesthesia for dependent children as required by law; educational training problem experimental and investigational procedures; eye glasses and contact lenses; hearing a fitting; learning disorders; marital or social counseling; nursing home care except as spe otherwise covered under this plan; sexual dysfunction, infertility treatment and counseli specifically otherwise covered under the policy requirements of this plan; TMJ with no n treatment for work-related illnesses and injuries except for those individuals who are no maintain or be covered by workers' compensation insurance as defined by workers' cor laws [26]; transplants except for those listed above; and war.			

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for your 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 (i.e., go In-network) than If you don't (i.e., go out-of-network).

1a Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maxlmums) levels apply *ONLY IF* plan has network providers for

2 "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. Copays for prescription drugs, however, are not applied to the out-of-pocket maximum. Under the standard plan, co-pays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

3 However, neither the individual nor the family out-of-pocket HMO annual maximum may exceed 200% of the annual premium, if federally qualified.

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 out-patient psychotherapy visits for biologically-based mental illnesses.

6 See Attachment 1 for list of covered preventive services.

7 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

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.

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.

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

12 “Emergency care” means services delivered by an emergency care facility which 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 by the carrier or their primary care physician to the emergency room for care. If emergency rooms are used by the plan for non-emergency after hours care, then urgent care 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 Section 10-8-606(2), 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 Section 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 Section 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 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 numbers 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 you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for 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 pian, is responsible for medical benefits for work-releted illnesses and injuries. Also if this plan is 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 ServicesAll 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	Imunizations. (Covered immunizations are listed

	at the end of this document.)Immunization deficient children are not bound by “recommended ages” on immunization chart.
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[1]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[2] every year
	1 Td
	Females: screening pap smears not to exceed 1 per year
	1 hepatitis B vaccination if not given, previously
Age 19-39	1 Td every ten years
	1 age appropriate health maintenance visit every three years
	1 fasting lipid panelFemales ages 35-39; 1 baseline mammogram and clinical breast exam (**Covered Under Standard Plan Only**)
	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 between ages 50 and 75
	1 age appropriate health

	maintenance visit every 24 monthsFemales ages 40-49: 1 screening mammogram and clinical breast exam every 2 years(annually, if high risk) (**Covered Under Standard Plan Only**)
	Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months (**Covered Under Standard Plan Only**)
	Females: screening pap smears not to exceed 1 per year
	Males: Prostate screening as specified in state law (**Covered Under Standard Plan Only**
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

[1]"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.

[2]"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).

Current Recommendations for Routine Immunization of Infants and Children in The United States *

Recommended Age	Immunizations	Comments
Birth	Hepatitis B	For infants born to mothers who are HBsAg-positive. Initial dose must be given with 12 hours of birth. Also HBIG within 12 hours.
1 month	Hepatitis B	To be given to children of HBsAg-positive mother.
2 months	DTP-HIB or DTP and HIB Polio *(IPV or OPV) Hepatitis B Pneumococcal	Must check for immunosuppression prior to oral polio administration- -see special HIB schedule. May initiate Hepatitis B in HBsAg- negative family.
4 months	DTP-HIB or DTP and HIB Polio *(IPV or OPV) Hepatitis B Pneumococcal	May give all immunizations if given in different locations. 6-8 week minimum interval for oral polio.
6 months	DTP-HIB or DTP and HIB Polio *(IPV or OPV) Hepatitis B Pneumococcal	Note change-Total of polio remains the same. Third CPV given at 6 months instead of 15-18 months.
12 months	Pneumococcal	
12 -18 months	Varicella	It is unknown at this time whether chicken pox vaccine boosters will be needed and how often. Parents may choose instead to allow their children to catch the natural disease which provides lifelong immunity.
12-15 months	MMR	Since 92% of children immunized against measles at 12-14 months of age are protected,

		routine administration of measles vaccine is recommended from 12-15 months. Tuberculin testing may be done during this visit. MMR is recommended over single vins vaccines.
15 months	HIB	Any HIB may be used.
15-18 months	DTP, Polio DTaP may be used	May be given at 15 month or 18 month visit
24 months- 18 years	Hepatitis A	For high risk children.
4-6 years	DTP, Polio DTaP may be used	At or before school entry.
4-20 years	MMR	A second dose should be given upon entry to elementary school or at any opportunity including entry to college.
11 -12 years	Hepatitis B Varicella (if not received earlier)	Adolescents who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series at this time.
12 years	Varicella	For those children who have not had chicken pox by this age.
16 years	Td	Repeat every 10 years throughout life.

*The ACIP and AP recommend that the first two polio vaccinations be IPVs and the second two be OPVs. Schedules with all OPVs or IPVs are also safe and effective.

Sources: This table is based on the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. ABBREVIATIONS: DTP - diphtheria-tetanus-pertussis vaccine; OPV - oral polio vaccine; IPV injected polio vaccine; MMR - measles-mumps-rubella vaccine; Td - diphtheria-tetanus vaccine; DTaP - diphtheria-tetanus-acellular pertussis vaccine.

2004 recommendations were not available at time of publication. Carriers that adopt the 2004 recommendations of the ACIP/AAPP when available shall be deemed to be in full compliance with the requirements of the regulation as well as requirements for child health supervision services pursuant to § 10-18-104"(11). C.R.S.

Amended Regulation 4-6-7 Concerning Premium Rate Setting For Small Group Health Plans

Section 1. Authority

Section 1. Authority

This regulation is promulgated under the authority of Sections 10-1-109(1), 10-16-102(10)(b)(II), 10-16-104.9,10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, Colorado Revised Statutes.

Section 2. Purpose

The purpose of this regulation is to establish and implement rules for setting premiums for small group health benefit plans. This regulation concerns: applicability and scope of Colorado's small group health rating laws; carriers' obligations to provide coverage; premium rate setting; use of composite rates; rate filings; and actuarial certifications.

Section 3. Applicability and Scope

This regulation shall apply to all health benefit plans subject to the small group laws of Colorado.

Section 4. Definitions

A. “Filed rate” means the Index Rate as adjusted for plan design and the case characteristics of age, geographic location, and family size only. The “filed rate” does not include the Index Rate as further adjusted for any other case characteristic (See Section 5(A)(3) of this regulation),

B. “Metropolitan statistical area (MSA)” is a relatively freestanding area of the state determined by one or more large population nuclei, together with adjacent communities, that have a high degree of economic and social integration with the nuclei. Each MSA is not closely associated with another MSA. An MSA is a statistical standard developed for use by the Federal Office of Management and Budget, following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

C. “Premium rate,” “rate” and “premium” mean all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a carrier, including any fees or other contributions associated with obtaining or administering the health benefit plan.

D. “Primary metropolitan statistical area (PMSA)” is a possible subcategory of an MSA, which has a million or more persons living in that MSA. The PMSA consists of a large urbanized county or

cluster of counties that demonstrate very strong internal economic and social links, in addition to close ties, to other portions of the larger area. Each PMSA is also determined by the Federal Office of Management and Budget following a set of officially published standards, including, but not limited to, the acceptable underlying population base.

E. "Qualified actuary" means an actuary who meets the requirements of Colorado Insurance Regulation 1-1-1.

F. "Renewed." A health benefit plan is deemed renewed upon the occurrence of the earliest of: the anniversary date of issue; or the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan.

Section 5. Premium Rate Setting

A. Calculating Premium Rates Adjusted for Case Characteristics

(1) Index Rate – Each carrier offering a health benefit plan to groups in Colorado shall develop a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal. It should be calculated using the experience for all small group plans. The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.

(2) Plan Design Adjustment – The Index Rate may be adjusted to reflect differences attributable to different plan designs. If the small employer carrier elects to make this adjustment, the small employer carrier should calculate a rate adjustment factor for each small group plan design. Differences in the rates for different benefit plans, for persons with the case characteristics of age, geographic location and family size, shall be attributable to plan design only. Using this methodology, a carrier's rates for a plan with richer benefits than the Colorado Standard Health Benefit Plan should be higher than the rates for its Colorado Standard Health Benefit Plan, and a carrier's rates for a plan with leaner benefits than the Colorado Standard Health Benefit Plan should be lower than the rates for its Colorado Standard Health Benefit Plan.

(3) Acceptable Case Characteristic Factor Categories – For all small employer policies carriers choosing to modify the unique index rate by the use of case characteristics must utilize one or more of the categories listed below. Carriers shall develop a rating factor for each category, which is actuarially based.

(a) Age – if a carrier uses age to calculate rates, then it shall use the following 12 mandatory age categories. Rates must be based on employee age only, not employee and spouse ages.

Mandatory Age Categories
Children ages newborn through 19 years (24 years if child is a full-time student covered as a dependent), excluding emancipated minors
Emancipated minors and

persons ages 19 through 24
Age 25 through 29
Age 30 through 34
Age 35 through 39
Age 40 through 44
Age 45 through 49
Age 50 through 54
Age 55 through 59
Age 60 through 64
Age 65 and older: Medicare is primary payer
Age 65 and older: Medicare is secondary payer

(b) Geographic Location – if a carrier uses geographic location to calculate rates, then it shall use the 9 mandatory categories listed below. In determining that these geographic location categories best serve the public interest, the commissioner considered the key issues of accessibility, availability, consumer choice and the cost of health care in all areas of the state. Public and consumer input was solicited, received, and evaluated. The commissioner determined that these area groupings best serve the public interest by maximizing consumer choice options and health care availability in all areas of the state at the lowest possible cost and will ensure that the rates charged are not excessive, inadequate or unfairly discriminatory. The appropriate population base for these categories is the base as determined by the federal government in establishing MSAs, except for the last two categories listed below. No MSA exists for these counties and consequently these counties were grouped by population size. Carriers may, with the prior written approval of the commissioner, establish one or more additional categories by further subdividing the last two categories.

Rates must be based on the primary physical location of the small employer's business, except that an employer with multiple business locations in separate geographic categories may be provided with separate rates for each physical business location. There cannot be a separate factor for a small employer's out-of-state employees, if any. These individuals shall be rated as if they are working in the small employer's primary physical business location.

Mandatory Geographic Location Categories
Boulder County (known as the Boulder-Longmont PMSA)
Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties (known as the Denver MSA)
Weld County (known as

the Greeley PMSA)
El Paso County (known as the Colorado Springs MSA)
Larimer County (known as the Fort Gollins-Loveland MSA)
Mesa County (known as the Grand Junction MSA)
Pueblo County (known as the Pueblo MSA)
Counties in Colorado with a population of 20,000 or fewer residents: Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Elbert, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Las Animas, Lincoln, Logan, Mineral, Moffat, Ouray, Park, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, and Yuma counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)

All other Colorado counties: Delta, Eagle, Fremont, Garfield, La Plata, Montezuma, Montrose, Morgan, and Otero counties. (Such counties may be grouped into one or more geographic location categories based on differences in medical costs of the carrier with the prior written approval of the Commissioner.)

PMSA = Primary Metropolitan Statistical Area

MSA = Metropolitan Statistical Area

(i) Geographic rating factors must be determined on the same basis, reflect the relative differences in expected costs, and produce rates that are not excessive, inadequate, or unfairly discriminatory in such geographic areas. For example, a geographic factor of 1.2 for the Colorado Springs MSA and a factor of 1.0 for the Denver MSA would imply that costs can reasonably be expected to be 20% higher in the Colorado Springs MSA than they are in the Denver MSA. All changes in the geographic rating factors must be supported on this basis.

(ii) Approval to subdivide categories eight and nine above into two or more subcategories must be obtained in advance. The material provided to support the subdivision(s) shall be based upon statistically-credible data using the Division of Insurance's credibility standard and/or other actuarially- determined standards. The Division's credibility standard is 2,000 life-years and 2,000 claims per year. (See Section 5(A)(7)(c)(ix)(2) of Amended Colorado Insurance Regulation 4-2-11).

(c) Family Size – if a carrier uses family size to calculate rates, then it shall use the 4 mandatory categories listed below. If age is also used as a rating factor, rates must be based on employee age only, not employee and spouse ages.

Mandatory Family Size Categories
1 adult
2 adults
1 adult plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.
2 adults plus any number of children who are dependents of the primary insured or for whom the primary insured is legally required to provide health insurance coverage.

(d) Smoking Status – A carrier may offer small group policies that include a premium discount not to exceed ten (10) percent for each individual that has refrained from smoking for more than twelve (12) consecutive months prior to the effective date or renewal date of the small group nonsmoker policy. Proof of nonsmoking status, acceptable to the carrier, may be requested when the policy is issued or renewed. Carriers are advised that there are other requirements under federal law as to the use of smoking status as a small group rating variable.

(e) Health Status – If a carrier uses health status to calculate rates, only one factor is permitted for each small group. A health questionnaire, requesting reasonable information, may be used to help determine this factor provided that the same questionnaire is utilized in the determination of the factor for all small groups. It is acceptable to evaluate the health status of new enrollees by use of this questionnaire and to evaluate the health status of renewing group enrollees by use of the Claims Experience case characteristic. If this information is unknown for either the small group or the new enrollee, the small group and/or the enrollee should be considered “average” as determined over all small group plans and a rating factor of 1.0 should be utilized. If the small group does not provide any reasonably requested information, the carrier may assign its highest possible health status rating factor to this small group. If it is determined that the small group has provided inaccurate information, or information that would affect the rating factor, the carrier may retroactively adjust this rating factor to the date this information was provided, and charge the small group accordingly. No enrolled employee should be charged directly for any adjustment to the “average” factor.

(f) Claims Experience – If a carrier uses claims experience to calculate rates, only one factor is permitted for each small group. If this information is unknown for either the small group or the new enrollee, the small group and/or the enrollee should be considered “average” as determined over all small group plans, and a rating factor of 1.0 should be utilized. No enrolled employee should be charged directly for any adjustment to the “average” factor.

(i) New policies – Claims experience is an allowable case characteristic for new policies only if the available data from other sources is comparable to the carrier's claims experience used to determine this factor. Any request by a carrier for this information shall not violate federal and state privacy laws.

(ii) Renewing groups – While this factor should be determined by evaluating the claims experience of the renewing group, the health status of any new enrollee may also be considered. If the small group's experience for the current rating period does not provide a reasonable basis for quoting a new claims experience factor, the claims experience rating factor for the current rating period may be used for the new policy year.

(g) Standard Industrial Classifications – If the carrier uses the standard industrial classifications to calculate rates, only one factor is permitted for each small group. No enrolled employee should be charged directly for any such adjustment.

(h) All rating adjustments due to the application of any of these case characteristics must be applied consistently in the calculation of all small employers' rates. Any adjustments made due to health status, claims experience and standard industrial classification should be applied uniformly to the rates charged for all employees enrolled under each small group policy.

(4) Limits on Certain Case Characteristic Adjustments – For all small group health benefit plans issued or renewed for a small employer on or after September 1, 2003, rating adjustments based on health status, claims experience, and standard industrial classification shall not result in a rate that deviates from the carrier's filed rate by more than a fifteen percent decrease (15%).

B. Rating Period

The rating period for all small group health plans shall be twelve (12) months unless:

(1) A small employer carrier specifies in its rate filings a different rating period, which shall be the same for all its small group health benefit plans issued or renewed in the same calendar month, pursuant to Section 10-16-105(8)(c)(II), C.R.S.; and

(2) The small employer carrier clearly discloses in all its small employer solicitation and sales materials exactly what the different rating period is, pursuant to Section 10-16- 105(5)(b), C.R.S.

C. Administrative and Other Fees

Carriers and producers shall not charge any fees in addition to premium, except for amounts charged as necessary to recoup assessments paid for CoverColorado. Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Such charges must be built into the index rate and are not an allowable rate adjustment factor. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

Section 6. Use of Composite Rates

A. Small employer carriers may offer the small employer rates calculated by use of the following methods subject to the following restrictions:

(1) Four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation; OR

(2) A choice between four-tier, age-banded rates, calculated pursuant to Section 5 of this regulation, and composite rates. It shall be construed that the small employer carrier has offered the small employer a choice between the two methods if, at initial application and at each renewal :

(a) Both methods are offered to the small employer, with the differences clearly explained in writing; OR

(b) The small employer is given a written option to indicate that: 1) both rating methods need be presented; or 2) only age-banded rates need be presented; or 3) only the composite rate need be presented. This indication may be a check-off on the application or renewal form or other similar form that complies with this section.

B. Small employer carriers may offer small employers composite rates as an alternative to four- tier, age-banded rates calculated pursuant to Section 5 of this regulation if all of the following conditions are met:

(1) The small employer carrier makes the same offer across its entire book of Colorado small group business where an employer has ten (10) or more eligible employees. If the small employer carrier makes this offer to all small employers having ten (10) or more eligible employees, then the small employer carrier may also offer composite rates to small employers having fewer than ten (10) eligible employees. The small employer carrier must establish a pre-determined minimum size for offering composite rates. The same offer must be made available to all small employers having at least this pre-determined number of eligible employees.

(2) The small employer carrier must clearly state on its application and renewal forms for all of its small group products the differences between age-banded and composite rates and that either:

(a) The minimum number of eligible employees for calculating composite rates is ten

(10) and that all small employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates, and have the right to see them calculated either or both ways; OR

(b) If the number of minimum eligible employees is less than ten (10), the small employer carrier shall state the minimum number and that all small employers with at least this minimum number of eligible employees are entitled to a choice of composite rates or four-tier, age-banded rates, and have the right to see them calculated either or both ways.

(3) Calculating Composite Rates:

(a) New Policies – At the time of the initial application by the small employer, composite rates must be calculated separately for each small employer, based upon the small employer's actual enrollment as of the effective date.

(b) Renewing Groups – At renewal, composite rates must-be calculated for each small employer group based on enrollment as of the date of the renewal calculation, or as of the effective date for the renewal rates, which shall be consistent for all small employers. A second quote, subsequent to the date of the renewal calculation, may be calculated IF the demographics of the small group have changed significantly since the date of the original renewal quote, and the carrier recalculates the composite rates in all similar circumstances. If the carrier retains the right to revise the original calculation, this right must be clearly disclosed. Despite changes in the demographic composition of the small employer group, composite rates shall be set, as of the renewal date, for a particular small employer for the entire rating period.

(4) The small employer carrier uses the same composite rating methodology for all small employers. The small employer carrier may offer composite rates on a two tier (i.e. employee and employee plus dependents), three tier or four tier composition basis. If the small employer carrier elects to offer these three choices, it is at the employer's sole discretion whether the composite rates are set on the two-tier, three-tier, or four-tier family composition basis. However, the basis for the calculation of initial premiums before composite rating for a particular employer must be based on four-tier family, age-banded rates calculated pursuant to Section 5 of this regulation.

(5) At the time of the initial application by the small employer, the composite rating and four-tier family, age-banded rating for a particular small employer must result in identical total premium collections due from that employer for the first month of the rating period. At renewal, the composite rating method and four-tier family, age-banded rating methods for each small employer must result in identical total premium amounts as of the date of the renewal calculation. Assuming there is no change in the demographic composition of the small employer group, composite rating and four-tier family, age-banded rating for a particular employer must result in identical total premium collections due from that employer for a given rating period.

C. Nothing in this section shall be construed to require carriers to provide other than four- tiered, age-banded rates.

Section 7. Rate Filings and Actuarial Certification

A. The provisions of Sections 10-16-105(6.5) and 10-16-107, C.R.S., and Colorado Insurance Regulation 4-2-11 shall apply to the filing of rates for small employer health benefit plans.

B. Small employer health benefit plan rate filings shall not be combined with either individual or large group rates. Additionally, they shall be filed separately by type of coverage (indemnity, preferred provider organization, or health maintenance organization).

C. Pursuant to Section 10-16-105 (6.5), C.R.S., all carriers who sell, or offer for sale, policies subject to the requirements of this regulation, must submit an annual actuarial rate certification to the Division of Insurance prior to March l of each calendar year. Note – this certification may be combined with the Company's Annual Rate Report. (See Section 5 (C) of Amended Colorado Insurance Regulation 4-2-11.) Certifications shall be sent to the Colorado Division of Insurance, Attention: Rates and Forms Section. The certification must be signed by a qualified actuary and must contain at least the following:

(1) The name of the carrier and the identification number assigned by the National Association of Insurance Commissioners;

(2) A list of all plans of health benefits and policy forms to which the certification applies;

(3) A statement that covers at least the points listed in the following illustration: “In my opinion, as of January l of the year of this certification, the premium rates and rating methodology to which this certification applies are neither excessive, inadequate nor unfairly discriminatory, and they meet the requirements of the insurance laws and regulations of Colorado;”

(4) The name and title of the qualified actuary signing the certification, and the name of the firm with which he or she is associated; and

(5) The original signature of the qualified actuary and the date of the signature. Signature stamps or signature on behalf of the actuary are not acceptable.

Section 8. Enforcement

Noncompliance with this regulation may result, after notice and opportunity for hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 9. Severability

If any provision of this regulation or the application thereof to any other person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

Section 10. Effective Date

This Amended Regulation will be effective for policies, which are issued or renewed on or after April l, 2004.

Section 11. History

Emergency Regulation 94-E-4; Effective October 20,1994.

Emergency Regulation 95-E-2; Effective January 20,1995.

Hearing date: December 8,1994; Effective March l, 1995.

Hearing date: April 2,1998; Effective June l, 1998, Amended Sections 2,3,4,5,6,7 & 10.

Hearing date: October 2,2000; Effective January 1, 2001, Amended Sections 5 & 6.

Hearing date: September 4,2002; Effective January l, 2003, Amended.

Hearing date: February 4,2003; Effective March 31,2003, Amended Sections 1, 5,10 & 11.

Emergency Regulation 03-E-6, Effective September l, 2003.

Hearing date: October l, 2003; Effective December l, 2003, Amended Sections 4, 5, 6, 7,10 & 11.

Hearing date: February 2004; Effective April l, 2004, Amended Sections 5,10, & 11.

Amended Regulation: 4-6-8 Concerning Small Employer Health Plans

Section 1. Authority

This regulation is promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(l)(a)(TV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S.

Section 2. Purpose

The purpose of this regulation is to establish rules for implementing Colorado's small group laws. This regulation concerns the applicability and scope of the small group provisions; carriers' obligations to provide coverage; employee eligibility requirements; the use of restrictive riders; rules relating to fair marketing; special provisions that apply to business groups of one; and carrier disclosure requirements.

Section 3. Definitions[1]

A. “Actively marketed” means with respect to a small employer health benefit plan offered by a carrier that the carrier uses at least the same sources and methods of distribution that it routinely uses in Colorado to market its most frequently sold small employer health benefit plan.

[1]Refer to the Colorado Revised Statutes for additional definitions of language contained in this regulation.

B. "Clear and conspicuous" means that a disclosure is reasonably understandable and designed to call attention to the nature and significance of the information in the disclosure. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

(1) Uses a typeface and type size that are easy to read;

(2) Uses a type size that is greater than the type size predominantly used in the communication;

(3) Provides wide margins and ample line spacing;

(4) Uses boldface, capitals or italics for key words; and

(5) In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the notice or uses distinctive type size, style, and graphic devices, such as shading or sidebar.

C. "Limited benefit health insurance" means a health policy, contract or certificate offered or marketed as supplemental health insurance that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a health benefit plan. "Limited benefit health insurance" does not include short-term limited duration health insurance policies, contracts or certificates; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term "health benefit plan" as defined in Section 10-16-102(21), C.R.S.

D. "Renewed" for the purposes of this regulation, means that a health benefit plan is continued upon the occurrence of the earliest of: the anniversary date of the employer's plan; the date on which premium rates are or by the terms of the plan can be changed; or the date on which benefits are or by the terms of the plan can he changed.

Section 4. Applicability And Scope

A. This regulation shall apply to any health benefit plan, whether provided on a group, group association, or individual basis, which:

(1) Meets one or more of the conditions set forth in Section 10-8-601.5 (I)(a)(I) through (IV) C.R.S., except as provided in Section 10-8-601.5(I)(c.5), C.R.S., and Section 4.J. of this regulation, and;

(2) Provides coverage to a business group of one or to one or more employees of a Colorado small employer, without regard to whether the policy or certificate was issued in this state, except as provided in Sections 10-3-903(2)(h), and 10-8-601.5(I)(c) and (3), C.R.S.;

B. A carrier that provides individual or group health insurance coverage to one or more of the employees of a small employer or to a person or entity that meets the definition of a business group of one shall be considered a small employer carrier subject to the provisions of this regulation if it meets any of the conditions found in Section 10-8-601.5 (I)(a)(I) through (IV), C.R.S., except as provided in Section 10-8-601.5(I)(c), (c.5) and (3), C.R.S.

C. The provisions of this regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size or is sponsored by an association, health care coverage cooperative or discretionary group, except as provided in

Sections 10-8- 601.5(l)(b) and 10-16-214(5), C.R.S.

D. If a small employer is issued a health benefit plan subject to the small group health insurance laws of Colorado, the provisions of this regulation and statutes concerning small group health insurance shall continue to apply to the health benefit plan in the event that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer no longer meets the definition of a small employer, but no later than the anniversary date of the employer's health benefit plan, notify the employer that the small employer health insurance provisions of Colorado law shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

E. If a health benefit plan is issued to an employer with more than fifty (50) eligible employees that is not a small employer but subsequently the employer becomes a small employer (e.g., due to the: loss or change of work status of one or more employees), the provisions of this regulation and statutes concerning small group health insurance shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier solely because the carrier continues to provide coverage under the health benefit plan to the employer. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notify the employer of the options and protections that may be available to the employer under the small group health insurance laws of Colorado, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

F.

(1) If a small employer has employees in more than one state, with no state containing a numerical majority of its employees, and if the primary business location of the small employer is in this state, then the provisions of this regulation and statutes concerning small group health insurance shall apply to the health benefit plan issued to such a small employer, except as provided under Section 10-3-903(2)(h), C.R.S. The number of employees in each state shall be determined as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(2) If a health benefit plan is subject to the small group health insurance laws of Colcrado, this regulation and relevant statutes shall apply to all individuals covered under the health benefit plan.

G. A carrier that is not operating as a small employer carrier in this state shall not become subject to Colorado's small group health insurance laws solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state.

H. A plan marketed to individual employees through an employer or at a place of business is subject to this regulation and all applicable small group laws unless a carrier can demonstrate that the circumstances of the sale, marketing, and continuation of such plan coverage meet the conditions established in Section 10-8-601.5(l)(a)(IV), (c) or (c.5), C.R.S., as further defined in Section 4.J. of this regulation.

I. A health benefit plan that meets the criteria listed in Section 4. A. of this regulation shall be subject to small group requirements even if it covers only one person. Examples include but are not limited to: a health benefit plan that covers the only employee of a small employer; a health benefit plan that covers just one employee because the other employees of a small employer have coverage under another health benefit plan and have waived off the plan; or a health benefit plan that covers the only employer-determined eligible employee of a small employer.

J. Pursuant to the authority granted to the Division of Insurance under Section 10-8- 601.5(l)(a)(TV), C.R.S., this regulation shall not apply to health benefit plans marketed by producers through an employer or at an employer's place of business to individual employees if ALL of the following conditions are met both at the time of marketing and sale, and continuously during the period of coverage:

(1) No portion of the premium or benefit is paid by or on behalf of a small employer;

(2) No person covered by the health benefit plan is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for any portion of premium;

(3) The health benefit plan is not treated by the employer or anyone covered by the plan who meets the definition of an eligible employee or dependent of an eligible employee as part of a plan or program for the purposes of Section 106, 125, or 162 of the Federal Internal Revenue Code of 1986, as amended, except as permitted in Section 10-8-601.5(l)(c.5), C.R.S.;

(4) If the health benefit plan is marketed to an employer's ineligible employees through an employer or at a place of business this marketing occurs only with the written permission or at the written request of the employer;

(5) There is an employer-sponsored health benefit plan already in place at the place of business where the health benefit plan is being marketed, except that this requirement shall not apply to a self-employed person;

(6) Except in the case of a self-employed person working out of the home, no billings, premium collections or other correspondence regarding the health benefit plan are sent to the place of business or otherwise involve the employer, except with respect to the initial marketing or administration of a Section 125 plan as permitted in Section 10-8-601.5(c.5). C.R.S; and

(7) The employee being marketed and/or sold the health benefit plan meets one or more of the following criteria:

(a) The employee will be terminating employment within thirty-one (31) days;

(b) The individual is a self-employed person with no other employees;

(c) The employee is a seasonal employee with an employment contract that .s shorter than the waiting period for coverage or is not eligible for coverage under his/her employer's health benefit plan;

(d) The employee is a temporary or substitute employee;

(e) The employee works less than twenty-four (24) hours a week on a regular basis;

(f) The employee has a dependent who was covered under the employee's employer-sponsored health benefit plan but that dependent is no longer eligible for such coverage, in which case an individual health benefit plan for such dependent may be marketed to the employee at the workplace;

(g) The employee is a late enrollee who is completely excluded from his/her employer's health benefit plan for a year; or

(h) The employee is in a waiting period for coverage under an employer-sponsored

health benefit plan and all the following conditions are met: the individual health benefit plan marketed to such an employee is a short-term health benefit plan that can be rewritten by the short-term carrier or any other carrier for a combined total of no more than twelve (12) months; the producer selling such a plan gives the employee an explanation of the employee's continuation rights under his/her prior employer's plan; and the employee is alerted by the same producer that, depending on the terms and conditions of the short-term policy, the employee may lose his/her right to credit for pre- existing condition periods met under a prior policy when he/she does become eligible for employer-sponsored coverage.

Section 5. Issuance Of Coverage

A. Providing Coverage

(1) A small employer carrier shall actively offer to all small employers in the carrier's service area a choice of all small group plans the carrier markets in Colorado, as set forth *in*Section 10-16-105(7.3)(a), C.R.S. A small employer carrier shall issue coverage under any of its small group plans for which a small employer makes application, except:

(a) Pursuant to Section 10-8-601.5(3), C.R.S., a small employer carrier is not required to offer coverage to a self-employed business group of one or sole proprietor who elects coverage under an individual policy issued pursuant to Section 10-8-601.5(l)(c), C.R.S., and who is covered under that policy for less than three years. To determine whether an individual has been covered under an individual policy issued pursuant to Section 10-8-601.5(3), C.R.S., for less than three years, small employer carriers shall refer to Colorado Division of Insurance regulation 4-2-19.

(b) A small employer carrier is not required to issue coverage to a business group of one that does not meet the carrier's normal and actuarially-based underwriting criteria except during the open enrollment period, which is defined as the 31 days following the birth date of the person qualifying as a business groups of one, or within 31 days of a special business groups of one qualifying event as defined in Section 10-16-105(7.3)(i), C.R.S. If the business group of one does not meet the company's underwriting criteria, the only coverage that must be issued during these periods is the applicant's choice of the Colorado Basic or Standard Health Benefit Plan.

(c) A small employer carrier shall be considered to have met the requirement to offer its small group product at the time a policy has been issued. In the event that a small employer's coverage is terminated due to non-payment of premiums, the carrier that issued the policy can deny a new application for the same small employer on the basis of this termination, except that:

(I) If the small employer is a group of 2-50 the application can be denied for six months after termination for non-payment or at the end of the original policy period, which ever is greater, or,

(II) If the small employer is a business group of one, the application can be denied for six months after termination or until the next open enrollment period, which ever is greater.

This provision shall not relieve the employer of its responsibility for payment of any outstanding premiums or late charges owed for the prior period of coverage.

(d) A small employer carrier shall be considered to have met the requirement to offer its small group product at the time a policy has been issued; therefore, a carrier does not have to honor requests to change policy provisions during the policy term.

(2) A small employer carrier shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. For managed care plans, an employee must either work or reside in the carrier's service area to be considered an eligible employee, except as provided in Section 10-16-704(2)(g), C.R.S. The small employer carrier shall provide the same health benefit plan under the same terms and conditions to each such employee and dependent, except that this requirement shall be waived for those individuals (and their dependents) who are employed by a participating employer within a bargaining unit covered by at least one collective bargaining agreement pursuant to which an employee benefit plan is established and maintained, and except as provided in paragraph 5.A.(5).

(3) A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans, except as provided in paragraph 5.A.(5). The choice among benefit plans may not be limited, restricted or conditioned based upon health status-related factors of the employees or their dependents. Nothing in this section limits the ability of a small employer carrier to set participation rules based upon group size that may limit the availability of multi- option plans to a single employer as long as any of the component plans offered could be accessed individually by any small employer.

(4) Small employer carriers may make the sale of any small group policy, except the basic and standard plans, conditional upon the sale of group life insurance if:

(a) The carrier prominently discloses in all of its sales and promotional materials, official offerings, and proposals that the offering of such coverage to all small employers is conditional upon the purchase of a specified level of group life insurance coverage;

(b) The carrier agrees to guarantee issue group life insurance; and

(c) The carrier includes with any small group plan proposal of coverage to a small employer the additional premium he or she will be required to pay for life insurance.

(d) The carrier makes the same offer to all small employers.

(5) A small employer carrier that only offers managed care plans may offer an indemnity plan to a small employer's out-of-area employees only (instead of to all employees). However, the following conditions may apply:

(a) A HMO may offer coverage through an arrangement with an insurance carrier as long as the coverage is only made available to the out-of-area employees of a small employer. The use of insurance coverage for this purpose only will not result in a requirement that the HMO or other carrier actively market the basic and standard indemnity health benefit plan and will not result in the other carrier being considered a small employer carrier.

(b) A HMO may offer coverage to the out-of-area employees of a small employer or a small employer located outside of the HMO's approved service area pursuant to the notice, disclosure, and reimbursement provisions as described in Sections

10-16-704(2) and (2.5), C.R.S. If an HMO offers coverage to one or more out-of-area employees of a small employer or small employers, it must offer it to all small employers.

(c) A carrier offering a managed care plan may offer indemnity coverage as long as the coverage is only made available to the out-of-area employees of the small employer. For these plans, out-of-area employees are those working and residing outside of tie state of Colorado. The use of insurance coverage for this purpose only will not result in the carrier being required to actively market the basic and standard indemnity health benefit plans.

(d) If a carrier offers indemnity out-of-area coverage to one or more small employers, it must offer it to all small employers.

B. Determining Who is an Eligible Employee, Dependent

(1) The Colorado Division of Insurance finds that, when defining “eligible employee” in Section 10-16-102(15), C.R.S., the sole intent of the General Assembly was to create a maximum weekly work requirement which small employer carriers may impose as a requirement for an employee's participation in a health benefit plan. Nothing in the definition of “eligible employee” was intended to limit an employer's traditional ability to set valid and acceptable standards for employee eligibility based upon the terms and conditions of employment, including a minimum weekly work requirement in excess of twenty-four (24) hours and eligibility based upon salaried versus hourly workers and management versus non-management employees.

(2) The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as “employer-determined eligible employees”). However, a carrier must offer coverage to all small employers for all employees with a regular work week of at least 24 hours on a permanent basis. The decision of a small employer to limit eligibility for coverage as provided for in subparagraph (1) of this subsection B shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives. The small employer carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees.

(3) A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list. The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof.

(4) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee (or each employer-determined eligible employee and their dependents if this is different than the list of eligible employees) who

declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage (e.g., covered under spouse's plan, cannot afford coverage, etc.) be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers forms shall be maintained by the small employer carrier.

Section 6. Restrictive Riders

A. Small employer carriers shall not place restrictive riders, endorsements or other policy provisions on a small group plan that would restrict coverage of particular individuals, except with respect to late enrollees as provided for in Section 10-16-118(l)(c), C.R.S. If a small employer carrier offers coverage to a small employer, such carrier shall offer the same coverage under the same terms and conditions (including provisions related to pre-existing conditions that are consistent with Colorado law) to all eligible employees of the small employer and their dependents.

B. Except as permitted in Section 10-16-118(l)(c), C.R.S., concerning late enrollees, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan.

Section 7. Rules Related To Fair Marketing

A. A small employer carrier shall actively market each of its health benefit plans to Colorado small employers in all areas where the carrier is authorized to conduct business.

B. Every health benefit plan offered by a small employer carrier to new groups with less than fifty- one (51) eligible employees shall be actively marketed to all groups that meet the definition of a snail employer pursuant to Section 10-16-102 (40), C.R.S. Managed care plans are required to maintain an adequate network pursuant to Section 10-16-704(1), C.R.S., and must have a participating provider for all covered benefits.

(1) HMOs are authorized to conduct business in the specific counties and/or zip codes approved by the Division of Insurance.

(2) A carrier offering a managed care plan that is not an HMO or HMO POS (Point-of- Service) plan must actively market its small group plans across the service area, which is defined as the entire state of Colorado.

(3) Carriers that are not able to maintain a sufficient network after good-faith efforts to contract may employ certain remedies as described in Sections 10-16-704(2) and (2.5), C.R.S.

C. Small employer carriers cannot deny an application for coverage from a group based on its size, if the group satisfies the definition of a small employer, except as permitted by law for business groups of one, unless, pursuant to Section 4 of this regulation, such small employer group is not subject to the provisions of this regulation.

D. Small employer carriers may establish participation rules that vary based upon group size as allowed in Section 10-16-105(7.4), C.R.S.; however, the required participation level shall not exceed 75% of eligible employees who are not covered by existing creditable group coverage or individual coverage that was legally obtained prior to the individual's eligibility for group coverage under the employer's existing group plan and consistently maintained by the individual.

For the purpose of determining participation, “group coverage” shall mean:

(1) Medicare or Medicaid;

(2) An employee welfare benefit plan or group health insurance or health benefit plan;

(3) A state health benefits risk pool (including but not limited to CoverColorado); or

(4) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal “Peace Corps Act” (22 U.S.C. Sec. 2504 (e)).

E. 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 it applies to other small group health benefit plans offered by the small employer carrier, except as allowed for cut-off dates and medically underwriting business groups of one.

F. A small employer carrier may establish underwriting rules that allow cut-off dates for business groups of one that are different from the cut-off dates for other small employers to the extent that additional time is needed to determine eligibility and perform medical underwriting. Such dates shall be consistent with the cut-off dates for similar medically underwritten business (e.g. individual products), if applicable. Under no circumstance shall the cut-off date be earlier than the first of the month prior to the requested effective date of coverage.

G. A small employer carrier shall provide a price quote without requiring verification of the eligibility of the small group, including business groups of one within 5 (five) working days of the request. 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.

H. A small employer carrier shall not establish small group producer commission or bonus programs in a manner that discourages marketing to very small groups. A commission or bonus program that establishes a lower payment rate such as a lower flat fee per employee or member or percentage of premiums for smaller employers based upon a group's size shall be considered risk avoidance and an unfair trade practice.

I. No producer or carrier shall advise, induce or encourage a small employer to arrange for coverage for an employee or dependent through CoverColorado or another mechanism for the purposes of separating such person from the group policy.

Section 8. Special Provisions Applicable To Business Groups Of One

A. A small employer carrier may request documentation as necessary to determine whether a small employer meets the definition of a business group of one for purposes of obtaining and maintaining small group health coverage.

(1) In order to determine whether a business group of one qualifies for small group health coverage, the business group of one must provide sufficient documentation that it has carried on significant business activity in the past year, and has gross income from active participation in the business for at least one year out of the most recent consecutive three-year period that is sufficient to pay for annual health insurance premium.

(2) In order to determine whether a business group of one has sufficient income to qualify for a carrier's small group plans, the business group of one must provide tax documentation of

the business's gross income. The amount shall be determined using the gross income for the business as indicated on the appropriate forms recognized by the Federal Internal Revenue Service for business income reporting. For corporations, the gross income is equal to total income reported to the Federal Internal Revenue Service.

(3) If the business group of one meets all eligibility requirements but the gross income is insufficient for the specific plan requested, the carrier shall determine if the income is sufficient for another small group plan offered by the carrier. The carrier shall notify the employer and provide an opportunity to enroll in another plan for the same effective date.

(4) A business group of one must provide sufficient information to show that the individual works full time (24 hours or more per week on a permanent basis). In most situations, the nature of the business and the business income information should be sufficient to verify that the business group on one is working full time. In the event that the nature of the business or the tax information would indicate that the individual may not be actively engaged in business on a full- time basis, the carrier may request additional information to reasonably determine whether the individual is employed on a full-time basis. Additional information that may be requested includes:

(a) Invoices, billing records, general ledgers or similar information for a portion of the past year not to exceed 3 months;

(b) Additional tax documentation substantiating that business activities are not passive;

(c) Organizational documents including business license, articles of incorporation, and by-laws as appropriate for the type of business; and;

(d) In the absence of the information listed above, the carrier may request business collateral materials including marketing materials, business forms, web site addresses, or similar information in an effort to verify eligibility.

Section 9. Disclosure Requirements

A. Pursuant to Sections 10-16-105(5) and 10-16-704(9), C.R.S., small employer carriers shall provide a disclosure in all small employer marketing and solicitation materials, in a clear and conspicuous manner, that:

(1) Specifies that the employer will not be considered part of a separate class of business;

(2) Specifies that premium rates for a specific employer will not be established or adjusted based upon the experience, health status or duration of coverage of employees of the small employer or its employee's dependents;

(3) Explains the employer's right to renew;

(4) Explains pre-existing condition exclusions;

(5) Discloses that rates for any and all small group products being marketed by the carrier in the Colorado small group market will be given to a small employer, upon either oral or written request of such employer, within five (5) working days of the request; and

(6) In the case of a managed care plan, explains the existence, availability and general nature of an access plan, (e.g., that an access plan exists for every managed care plan and that it lists hospitals, providers, referral procedures, grievance procedures and emergency coverage provisions).

B. Pursuant to Section 10-16-105(5), C.R.S., small employer carriers also shall include in all printed marketing and solicitation materials information as to the benefits and premiums available under all health benefit plans for which the employer is qualified. This requirement shall be satisfied if the carrier provides the following information:

(1) The policy number (if any), policy name and policy type (e.g., HMO, indemnity, point of service plan) for all the plans for which the employer qualifies; and

(2) A summary of the benefits available under all the plans for which the employer qualifies which highlights the most salient differences among the plans as required in Colorado Insurance regulation 4-2-20.

C. Small employer carriers are not required to include the disclosure information set forth in Sections 9A and 9B of this regulation on the Colorado Health Benefit Plan Description Forms described in Colorado Division of Insurance Regulation 4-2-20.

Section 10. Notice Of Intent To Participate As A Small Employer Carrier

A carrier shall not offer health benefit plans to small employers in this state, unless the carrier has filed with the Commissioner a notice of intent to operate as a small employer carrier.

Section 11. Enforcement

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

Section 12. Severability

If any provision of this regulation or the application thereof to any other person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

Section 13. Effective Date

This amended regulation will be effective as of March 2, 2003.

Section 14. History of Regulation 4-6-8

Originally issued as Emergency Regulation 94-E-5, effective October 20,1994.

Reissued as Emergency Regulation 95-E-3, effective January 20, 1995.

Issued as Regulation 4-6-8, effective March 1, 1995.

Amended sections 1,2,4,9, and 15 of Regulation 4-6-8, effective December 31,1995.

Amended sections 1 through 12 and 15 of Regulation 4-6-8, effective November 1, 1997.

Amended Regulation 4-6-8, effective March 2,2003.

Regulation 4-6-9 Concerning Conversion Coverage

Section 1. Authority

This regulation is promulgated under the authority of Sections 10-1-109(1) and 10-16-109, C.R.S.

Section 2. Purpose

The purpose of this regulation is to establish rules for implementing the statutory requirement that group carriers offer a choice of a basic and standard health benefit plan to persons entitled to conversion coverage.

Section 3. Applicability and Scope

This regulation shall apply to small group and large group health benefit plans subject to the group laws of Colorado and to all policies, plans and certificates subject to the provisions of Sections 10-16-108(1)(c), 10-16-108(2)(d), and 10-16-108(4), C.R.S.

Section 4. Definitions

A. "Conversion coverage" means that coverage provided by carriers pursuant to Sections 10- 16-108(l)(c), 10-16-108(2)(d), and 10-16-108(4), C.R.S.

B. "Renewed." A plan of health benefits is deemed renewed upon the occurrence of the earliest of: the anniversary date of issue; the date on which premium rates are or by the terms of the plan can be changed; or the date on which benefits are or by the terms of the plan can be changed.

Section 5. Choice of Basic or Standard Health Benefit Plans

A. All persons entitled to elect conversion coverage pursuant to Sections 10-16-108(l)(c), or 10-16-108(2)(d) and 10-16-108(4), C.R.S., shall be offered a choice of the basic or standard health benefit plans only. (The basic and standard health benefit plans and rules for their implementation are described in Colorado insurance regulation No. 4-6-5, C.C.R.)

B. All persons entitled to elect conversion coverage pursuant to Section 10-16-108(4), C.R.S., shall be offered a choice of the basic or standard health benefit plans only, except that, pursuant to Section 10-16-108(4)(b), C.R.S., a small employer carrier may offer as conversion coverage the basic health benefit plan only (instead of a choice of the basic or the standard health benefit plan) if all the following conditions are met:

(1) The applicant for conversion coverage is eligible for conversion coverage pursuant to Section 10-l6-108(4)(b), C.R.S., but is not eligible for conversion coverage under Section 10-16-108(1)(c) or (2)(a), C.R.S., and

(2) The small employer health benefit plan from which the applicant is converting had benefits which provided coverage for hospital and physician services which, in most respects, were significantly less generous than the standard plan and comparable to or less generous than the basic health benefit plan.

C. A carrier shall, at minimum, offer to an applicant for conversion coverage at least one basic conversion coverage health benefit plan and at least one standard conversion health benefit plan of the same type (i.e., traditional indemnity, preferred provider or health maintenance organization) as the coverage from which the applicant is converting. Carriers may also offer the other types of standard or basic health benefit plan conversion coverage to applicants. If a carrier offers several preferred provider or health maintenance organization plans, it may meet this requirement by offering the most managed care version of its preferred provider plans and the most managed care version of its health maintenance organization plans. For the purposes of this subsection B, "most managed care version" is that plan which, when compared to the carrier's other preferred provider plans or HMOs offers the consumer the greatest financial incentive for the utilization of network participating providers.

D. Carriers shall not offer other conversion coverage policies either in addition to or in lieu of the basic and standard health benefit plans. Conversion coverage under the basic and standard health benefit plans shall not be modified in any way, except that carriers may offer optional riders to the basic or standard health benefit plans which would add additional coverage, so long as such coverage is offered to all applicants for conversion coverage and guarantee issued to any such person requesting additional coverage.

Section 6. Conversion Coverage Policies Issued Prior to January 1,1995

A.

(1) All persons covered on a conversion coverage health benefit plan issued before January 1,1995, shall be notified by the carrier in writing each time their policy renews after the effective date of this regulation of their right to change from their existing policy of conversion coverage to conversion coverage under a choice of the basic or standard health benefit plans. Such notification shall:

(a) At the first such renewal after the effective date of this regulation, include the premium amounts the person would have to pay for his or her current conversion coverage plan, and for conversion coverage under the basic and standard health benefit plans;

(b) At the first such renewal after the effective date of this regulation, include a comparison of benefits under their current conversion coverage plan and conversion coverage under the basic and standard health benefit plans;

(c) At each renewal, allow a person on a conversion policy issued prior o January 1, 1995, thirty (30) days from the date the notice is issued to change from their existing conversion coverage plan to conversion coverage under a basic or standard health benefit plan.

(2) The decision to change conversion coverage shall be solely at the discretion of the policyholder.

B. Persons electing to change from a conversion coverage plan originally issued prior to January 1,1995, to conversion coverage under a basic or standard health benefit plan shall not be subject to any new pre-existing condition exclusion periods when they change plans.

C. Once a person has elected to change his or her conversion coverage to a basic or standard health benefit plan, a carrier shall not allow such person to change his or her conversion coverage again.

(1) A carrier shall not allow persons electing to change their conversion coverage to a basic health benefit plan to subsequently change their coverage to either a standard health benefit plan or to their prior conversion coverage, once they have been enrolled under a basic health benefit plan for conversion coverage.

(2) A carrier shall not allow persons electing to change conversion coverage to a standard health benefit plan to subsequently change their conversion coverage to either a basic health benefit plan or to their prior conversion coverage, once they have been enrolled under a standard health benefit plan for conversion coverage.

D. Carriers shall require all persons who elect to change conversion coverage pursuant to subsection A of this section 6 to sign a statement certifying that:

(1) The person understands that the decision to switch his or her conversion coverage to basic or standard health benefit plan coverage is solely his or hers to make;

(2) The person has not been encouraged or induced by the carrier, a broker, agent or their representative to switch coverage; and

(3) The person understands that once made, the decision to switch to conversion coverage under the basic or standard health benefit plan is irrevocable.

Section 7. Enforcement

Noncompliance with this regulation may result, after notice and opportunity for hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 8. Severability

If any provision of this regulation or the application thereof to any other person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected thereby.

Section 9. Effective Date

This regulation will be effective as of March 1,1995.

Regulation 4-6-10 Employee Leasing Companies And Health Care Coverage

Section 1 Authority

This regulation is promulgated pursuant to §§ 10-1-109,10-3-1110 and 10-16-109, C.R.S.

Section 2 Basis and Purpose

The purpose of this regulation is to establish and implement rules for health carriers that issue and renew health plans to employee leasing companies and client employers.

Section 3 Applicability and Scope

This regulation shall apply to all health carriers.

Section 4 Definitions

A. “Employee leasing company” shall have the same meaning as set forth in 8-70- 114(2)(a)(I),C.R.S.

B. “Employee leasing contract1' shall have the same meaning as set forth in 8-70- 114(2)(a)(II),C.R.S.

C. “Work-site employer” and “client employer” shall have the same meaning as set forth in § 8-70-114(2)(a)(III), C.R.S.

Section 5 Rules

A. Carriers shall ensure that health plans issued or renewed to employee leasing companies that have aggregated their work-site employers for purposes of sponsoring health coverage as permitted by § 8-70-114(2)(a)(VIII), C.R.S., conform with all laws applicable to large group health coverage products, where the total aggregated employees exceeds fifty.

B. Carriers shall issue or renew group health coverage directly to work-site employers, where the client employer meets the definition of a small group as required by law, where the employee leasing company does not sponsor a health plan for its client employers.

1. If the employee leasing company does not provide access to a group plan to work-site employers, then providing only administrative functions related to health coverage does not constitute “sponsoring” a health coverage plan. An employee leasing company shall not be considered to be sponsoring a health coverage plan where the employee leasing company performs only administrative functions related to health coverage purchased directly by work-site employers. Examples of administrative functions include, but are not limited to deducting premiums from work-site employer payrolls for delivery to the carrier; and administering premium collection for COBRA continuation coverage.

2. Employee leasing companies shall not be considered to be sponsoring a health coverage plan under this Subsection B of Section *5* where the employee leasing company provides health coverage solely for its own staff who are separate and distinct from the client employer employees.

C. Carriers may issue or renew health plans directly to work-site employers where the employee leasing company has aggregated work-site employees for purposes of sponsoring health coverage, but the client employer has declined the coverage, provided the employee leasing company offers to sponsor health coverage for the client employer at the time of initial contracting with the client employer and at least at each open enrollment period, and the carrier obtains access to the certification specified below.

1. An employee leasing company is sponsoring a health coverage plan where the employee leasing company is directly involved in the negotiation or procurement of the health plan for the work-site employers. An example of involvement in the negotiation or procurement of the health plan includes, but is not limited to instances where the employee leasing company requires the work- site employer to use a particular producer or carrier in order to obtain particular services or benefits through the employee leasing company.

2. The carrier providing the employee leasing company sponsored coverage shall retain access to the certification required pursuant to this Subsection C of Section 5. This access may be via contract or oral agreement with the employee leasing company, or by other means. The carrier shall make this certification available within a reasonable time upon request by the Commissioner. The certification shall be in writing, dated, signed and verified by an officer or other employee that has legal authority to bind the employee leasing company and by an officer or other employee that has legal authority to bind the client employer, and shall provide the following information:

a. A statement confirming that the employee leasing company sponsors large group health coverage for its client employers.

b. A statement confirming that the employee leasing company offered to sponsor the large group health coverage for the client employer but the client employer declined the offer.

c. A statement setting forth the reason the client employer declined the coverage offered to be sponsored by the employee leasing company.

d. A statement informing the client employer that it is eligible for the employee leasing company sponsored plan at least annually during the plan's open enrollment period.

e. A statement confirming that to the extent the client employer has or will seek health coverage that is not sponsored by the employee leasing company, the employee leasing company was not involved in any way in the procurement of this other coverage.

D. Carriers may offer health coverage to the employee leasing company's administrative staff separately from the coverage offered to the employees of the work- site employer; even where the employee leasing company aggregates client employer employees under § 8-70-114(2)(b)(VIII), C.R.S. The carrier may consider only the number of employee leasing company administrative employees for purposes of determining the applicability of small group or large group laws applicable to the particular plan offered to the employee leasing company's administrative employees.

E. Carriers providing employee leasing company sponsored health plans may require the employee leasing company to apply the carrier's contribution and participation requirements to discrete potential client employer groups prior to contracting, where:

1. The participation and contribution requirements are in writing and are developed by the carrier and not by the employee leasing company;

2. The participation and contribution requirements are the same for all potential client employers of that employee leasing company, and

3. The participation and contribution requirements are applied uniformly and in a non-discriminatory fashion to all potential client employers by the employee leasing company.

Section 6 Enforcement

Noncompliance with this regulation shall be considered an unfair method of competition and unfair or deceptive act or practice in the business of insurance pursuant to § 10-3-1104, C.R.S. and may result, after notice and opportunity for hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 7 Severability

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

Section 8 Effective Date

This regulation is effective March 31,2003.

Section 9 History

New regulation, effective June 1,2001.

Amended regulation, repealing section 5E and reformatting, effective March 31,2003.

Amended Regulation 4-7-1 Health Maintenance Organizations

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-16-109, 10-16-401(4)(O); and 10-15- 403(2)(b), C.R.S.

Section 2 Background And Purpose

The purposes of this regulation are to provide the requirements for licensure as a health maintenance organization (HMO) and establish standards for HMO organization and operations.

Section 3 Scope

This regulation applies to licensed HMOs or persons seeking to become licensed to operate an]3MO in Colorado.

Section 4 Definitions

As used in this regulation, and unless the context requires otherwise:

A. “NAIC” means the National Association of Insurance Commissioners.

B. “Material modification of the plan of operations” includes a change in service area, or the initial entrance or withdrawal from the Medicare, Medicaid or commercial market, or any other transaction or series of related transactions which the HMO could reasonably predict would involve a net increase or decrease of 20% or more in the number of HMO enrollees or result in a 20% increase or decrease in the HMO's net worth over a 12 month period based upon projected financial statements.

Section 5 Authorization Of Insurers And Nonprofit Hospital, Medical-Surgical And Health Service Corporations .

A. Any licensed health carrier may apply to the Division of Insurance to become licensed as an HMO, as defined in article 16 of title 10, C.R.S. If a licensed health carrier is authorized to hold a certificate of authority to operate as an HMO, the requirements of part 4, article 16, title 10, C.R.S., will apply in addition to the other requirements for its health carrier certificate of authority.

B. Nothing herein shall be deemed to amend the intent or provisions of article 20 of title 10, C.R.S. Any HMO product offered by a licensed health carrier is not provided coverage and protection by the Colorado Life and Health Insurance Protection Association Act.

Section 6 Application For Licensure

Any person seeking licensure as an HMO shall submit two copies of an application to the Corporate Affairs Section of the Division of Insurance (Division). Applications shall include all items as required under § 10-16-401(4), C.R.S., and the following:

A. A list of all persons who will ultimately control the proposed HMO. If the proposed HMO is organized as a stock company, the application.must identify, all persons who .directly or indirectly will own or control ten percent or more of the outstanding stock.

B. Biographical sketches of all the official persons of the organization, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association, officers, directors, organizers and controlling individuals. Biographical information shall be submitted on the NAIC Biographical Affidavit (form available upon request). A complete fingerprint set, as may be obtained from local law enforcement sources may be requested at the discretion of the Commissioner. Any person who has been involved with any adverse administrative action within the prior five years shall disclose such activity in the biographical affidavit.

C. The addresses of company offices and the HMO functions to be performed by each office, including sufficient information to verify compliance with the provisions of § 10-3-128, C.R.S.

D. A statement as to whether the HMO will be seeking Federal qualification.

E. Current financial information and three (3) year financial projections, including balance sheets and income statements, conforming to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

F. A description of the method of marketing including, at a minimum, proposed advertisements, solicitation material, use of brokers and agents, use of HMO staff, and marketing research that will indicate the ability to meet the enrollment projections.

G. Proposed enrollment and/or application forms.

H. An actuarial opinion supporting the proposed premiums or rates to be charged and the underlying actuarial report reflecting the methodology and assumptions used in arriving at the rates used within the projections. The opinion and report must be prepared using generally accepted actuarial standards and principles.

I. A description of the geographic service area by county. Where the service area will be a part of a county, appropriate zip codes may be used to describe the service area.

J. A list of contracting providers, by specific geographic area and by specialty within each geographic area along with a map clearly indicating the service area. If there are no providers or specialty providers within a specific geographic service area, a separate description of the method of providing covered services in said service area, or part thereof, shall be provided.

K. An access plan for each separate network.

L. A description of the provider network arrangements, including copies of specimen contracts. This description should include the due diligence procedures to be performed by the HMO to ensure performance of the- services by the participating providers.

M. A detailed description of the sources of funding of the HMO.

N. The filing fees as required by § 10-3-207, C.R.S.

O. An application for licensure as a foreign HMO must also include the following:

1. The most recent financial examination report conducted by the state of domicile.

2. The most recent market conduct report conducted by the state of domicile.

3. An original certificate of compliance or a certified copy of the certificate of authority from the state of domicile referencing the approved lines of authority.

4. An explanation of any limitations imposed by the state of domicile.

5. Disclosure of any administrative action currently pending or taken against the company within the last five (5) years.

Section 7 Organizational Changes

A. An HMO requesting a material modification in the plan of operations on file with the Division, shall provide two copies of the following:

1. The financial statement for the HMO prepared within 90 days prior to the date of request for a modification in the plan of operations.

2. To the extent applicable with regard to the modification, a list of providers under contract or who have committed to contracting with the HMO and a description of the provider network arrangements, including specimen copies of provider contracts. This description

shall provide due diligence procedures to be performed by the HMO to ensure performance of the services by the participating providers.

3. Three year financial projections disclosing the impact of the modification in the HMO operations. Include balance sheets and income statements which conforms to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

4. To the extent applicable with regard to the modification, a Memorandum and certification by a qualified actuary, supporting the proposed premiums or rates to be charged in the new service area(s) or for the new market.

    a. The certification shall include a statement that the rates are not excessive, inadequate or unfairly discriminatory.

    b. In the Memorandum, the actuary shall discuss the differences in provider agreements to the extent that the agreements affect the underlying premium or rate requirements.

    c. The Memorandum shall include justification and support for the difference, or lack of difference, between the rates to be charged for the new market or service area(s) and the existing rate(s).

    d. If the new operations include Medicaid business or other business in which the premium is set by the contract holder and not the HMO, the Memorandum shall provide justification that the premium received will be at least equal to the company's medical and administrative costs. If the actuary cannot provide such a justification the HMO shall provide an adequate explanation as to why the HMO would accept a premium which is not at least equal to the company's medical and administrative costs.

B. An HMO requesting to modify its approved plan of operations on file with the Division by withdrawing from the geographic service area or a market, shall provide two copies of the following:

1. A statement as to why the HMO is withdrawing from a service area or market.

2. Evidence that there will no longer be any enrollment in the portion of the service area at the time of the proposed withdrawal. Such elimination of enrollment in the affected area may be accomplished by nonrenewal according to Colorado statutes and regulations or by any other means acceptable to the Commissioner.

3. An affidavit that the HMO will honor existing coverage for any enrollee hospitalized on the date of such withdrawal from the portion of the geographic service until the date of discharge or arrangements are made for alternative coverage.

C. Changes to the basic organizational documents, such as articles of incorporation and related documents, shall be filed with the Corporate Affairs Section and approved by the Commissioner before filing appropriate documents with the Colorado Secretary of State.

Section 8 Fidelity Bond

Pursuant to § 10-16-405, C.R.S., the funds received from enrollees must be treated in a fiduciary capacity. In order to protect the HMO enrollees from misuse of enrollee funds, an HMO licensed in Colorado shall have fidelity coverage, meeting the requirements of Regulation 3-1-1, for all officers,

directors and employees who have access to the HMO funds.

Section 9 Reinsurance

A. An HMO may enter into reinsurance agreements under which its risks are indemnified by an insurer. Such agreements must conform to the provisions of § 10-3-118 et seq., C.R.S., and Colorado Insurance Regulation 3-3-2 (3 CCR 702-3).

B. Section 10-3-118, C.R.S., provides that an HMO may assume risks from another HMO provided it is licensed or authorized to write the type of coverage assumed.

C. An HMO may only assume contract obligations from another HMO with the Commissioner's prior written approval. Any assumption transaction shall follow the provisions of § 10-3-701, et seq., C.R.S., and Colorado Insurance Regulation 3-3-1 3 CCR 702-3. In all transactions subject to the provisions of § 10-3-701, et seq., the assuming HMO must be licensed in the ceding HMO's service area and must demonstrate the ability to service the proposed acquisition and continue to meet compliance with the availability, accessibility and quality of care requirements.

F. The guarantor must agree to file audited financial statements with the Division of Insurance for each year the guarantee is in place. Upon initial filing for approval for the guarantee, the most recent audit report must be submitted.

Section 12 Provider Agreements

A. An HMO must establish that executed agreements between the HMO and the providers; exist prior to licensure or granting of approval for an increase in geographic service area. Provider agreements must be maintained in Colorado in the HMO's administrative office or other designated office for examination and shall be made available to the Commissioner upon request.

B. In order to qualify as a covered expenditure, a provider, intermediary, IPA or other provider group contract or provider subcontract must have a “hold harmless” provision which substantially complies with the following:

1. Provider agrees that in no event, including but not limited to nonpayment by the HMO, insolvency of the HMO or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than the HMO) acting on his/their behalf for services provided pursuant to this agreement. This provision does not prohibit the provider from collecting supplemental charges or copayments or fees for uncovered services delivered on a 'fee- for-service' basis to HMO subscribers/enrollees.

2. Provider agrees that this provision shall survive the termination of this agreement, for authorized services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollees. This provision is not intended to apply to services provided after this agreement has been terminated.

3. Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the provider and the subscriber, enrollee, or persons acting on fees behalf insofar- as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this agreement.

4. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner has received written notification of proposed changes.

C. Every contract between an HMO and a provider shall contain a provision clearly setting forth the HMO's reimbursement arrangements with the participating provider, including any financial risk assumed by the participating provider. An HMO shall maintain evidence that it took reasonable steps to ascertain that the provider understands such arrangements and that the HMO has determined that the provider is capable of undertaking the financial risk assumed.

D. HMOs may only transfer financial risk to providers for services which the provider performs, or services which such provider controls, directs or influences. Out of network emergency services are not controlled, directed or influenced by the provider and financial risk for such services may not be transferred. Any individual arrangement may be submitted to the Commissioner to be reviewed on a case by case basis to determine its acceptability.

E. An HMO shall have available a continuous program and procedure for review of providers ensuring their ability to provide contracted services. At a minimum this program must include the following:

1. Financial review of intermediaries and providers accepting risk for services which they do not control, direct or influence directly from the HMO.

2. Review all provider subcontract specimen forms for compliance with applicable insurance statutes and regulations, availability of services and evaluation of risk transfers.

3. Procedures for review of the timely and accurate compensation of providers pursuant to contract.

4. Review of quality management, utilization review, credentialing and other health care management services, if being conducted by the intermediary, provider or subcontracting provider. The procedures and practices used must be the same as those approved for the HMO by the Executive Director of the Colorado Department of Public Health and Environment.

5. Procedures for assuring continuity of care and for making payments to subcontracting providers in the event of the insolvency of an intermediary or provider

6. The reviews in subsections 1 through 5, above, shall occur upon initial contracting with the intermediary, provider or subcontracting provider. Subsequent reviews shall be undertaken at least annually. Additional reviews should be undertaken as necessary based upon: (1) the results of previous reviews of the intermediary, provider or subcontracting provider; or (2) complaints from enrollees or .providers-or (3) other information which may impact the intermediary's ability to provide services or pay subcontractors.

Section 13 Administrative And Other Service Agreements

A. An HMO may contract for the performance of administrative functions. Any contract for administrative functions shall contain the following:

1. Ninety (90) days written notice of cancellation to the Commissioner;

2. A provision that the contract may not restrict the HMO's Board of Directors from appointing, removing or changing officers or employees of the HMO;

3. A statement of the administrator's compensation, duties and responsibilities;

4. State that all books, records, assets, and liabilities of the HMO shall, at all times, remain the property of the HMO; and

5. If the HMO contracts for Electronic Data Processing (EDP) and/or Management information Systems (MIS), a provision providing appropriate access to the system upon examination by the Commissioner, and a mechanism under which the system is available to the HMO or its successor upon insolvency of the HMO, or termination or cancellation of the contract.

B. All management agreements and any material amendments thereto shall be filed with the Division of Insurance for review 30 days prior to the effective date. Agreements filed in compliance with § 10-3-805(4)(a)(IV), C.R.S., need not be filed under this regulation. For purposes of this regulation, management agreements means any agreements between the HMO and any entity or person not employed by the HMO for the purpose of managing the day to day operations of the HMO.

C. An HMO may offer administrative or other services to another person to the extent nor inconsistent with the provisions of article 16 of title 10, C.R.S., provided that:

1. The provider network is sufficient to absorb any enrollment from such action and the availability, accessibility and quality of the services to the HMO's enrollees are not impaired;

2. The arrangement entered into may be terminated by the HMO if such obligation substantially interferes with the HMO's operations or its ability to maintain compliance with law; and

3. The contract shall constitute the HMO's entire service obligation and shall be filed with the Commissioner.

Section 14 Financial Reports

A licensed health carrier also licensed as an HMO shall include the following exhibits of the EMO Convention blank detailing their HMO activities-as appendices to its NAIC convention blank fling;:

A. The income and loss statement for total business and Colorado business;

B. The enrollment report for total business and for Colorado business;

C. The schedule reflecting health care receivables for total business and Colorado business;

D. The claims payable analysis for total business and Colorado business;

E. The summary of transactions with providers for total business and Colorado business; and

F. Any other form of the NAIC blank the Commissioner requires to analyze the business of the HMO including, but not limited to, electronic filing.

Section 15 Property Acquisition

Section 10-16-403(1), C.R.S., provides that an HMO may acquire property which may reasonably be required for its administrative offices or for such other purposes as may be necessary to accomplish the business of the organization. The following rules apply in order to meet the requirements of § 10-16-403(2), C.R.S., regarding the prior approval of property purchases. Any property acquired without filing a notification, other than as outlined herein, shall be nonadmitted for statutory accounting purposes.

A. For acquiring real property, e.g. hospitals, medical facilities, nursing care and intermediate care facilities, an HMO must file, at least 30 days prior to acquisition, notice of its intent to acquire property. The filing shall include a description of:

1. The nature of the real property;

2. The location of the real property;

3. Method of acquisition (build new facility, remodel existing facility, etc.);

4. How the property contributes to the accomplishment of the nature of the HMO's business; and

5. An estimate of the amount to be expended and source of funding (i.e. loans, operating funds, etc.).

B. Electronic data processing equipment and software shall be admitted and valued in accordance with the statements of statutory accounting principles contained in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

C. The HMO may acquire property which is other than real property and which is used in the direct delivery of health care services, such as Pharmaceuticals and surgical supplies, durable medical equipment, furniture, medical-equipment and fixtures, and leasehold improvements -in health care facilities.

1. Furniture, medical equipment and fixtures and leasehold improvements in health care facilities must meet the following conditions in order to qualify as an admitted asset

   a. useful life of at least two (2) years; and

   b. cost of more than $500.00.

2. The aggregate admitted value of all property other than real property is limited to the lesser of 5% of assets or 25% of surplus.

3. The Commissioner may waive the aggregate limitations of subsection 2 above. A request for waiver must include:

   a. A detailed list and cost of each item;

   b. An explanation of why the property is necessary for the conduct of the business of the HMO;

   c. A statement as to why the request would not result in a deterioration of the liquidity or solvency of the HMO; and

4. Property other than real property shall be carried at the lesser of cost at the time of request less accumulated depreciation or the market value at the time of valuation, unless it is an asset whose method of valuation is specified in the insurance laws, regulations, or nationally recognized insurance statutory accounting principles.

5. The admissibility of property other than real property is subject to review and restriction of admissibility when the net worth of an HMO, less the admitted value of property subject to this section, is below the statutory minimum net worth as required by § 10-16-411, C.R. S., or if such property will cause a hazardous financial condition as determined by Colorado Insurance Regulation 3-1-7 (3

CCR 702-3).

6. A licensed health carrier, also authorized to hold a certificate of authority directly 1o operate an HMO, is restricted to the property which is admitted under rules applicable for the certificate of authority of the licensed health carrier.

D. The admitted value of property, other than real property acquired and admitted prior to January 1, 2001, which is not used in the direct delivery of health care services, may be phased out over a period not to exceed three years. The rate for phasing out the admitted value of such property shall be documented in the HMO's records, available for examination by the Division.

Section 16 Complaint Records

Pursuant to § 10-16-409, C.R.S., a complaint system is to be maintained by an HMO. As part of the complaint system, an HMO shall maintain a Complaint Record Maintenance which has the information required in Colorado Insurance Regulation 6-2-1, (3 CCR 702-6) and information regarding malpractice claims as required by § 10-16-409(I)(b)(III), C.R.S.

Section 17 Confidentiality

A. Except for the information submitted in compliance with § 10-16-107, C.R.S., (annual actuarial rate certification filing), documents filed with the Division of Insurance shall generally be considered public records under the Public Records Act, § 24-72-201, et. seq., C.R.S.

B. If an HMO considers a document to be confidential, it must submit the document under separate cover or in a file clearly labeled “CONFIDENTIAL” and a typed explanation of why the document is considered confidential.

C. Documents found to be confidential by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

Section 18 Enforcement

Noncompliance with this regulation may result in an administrative action pursuant to 16-4 19, C.R.S., or as otherwise provided by statute.

Section 19 Severability

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

Section 20 Effective Date

This regulation shall be effective January 3 1,2003.

Section 21 History

Originally issued as regulation 74-21, effective 1974.

Re-codified as Regulation 4-7-l) effective December 1, 1993.

Regulation Amended, Effective September 1,1999.

Regulation amended effective July 1,2001.

Regulation amended effective January 3 1,2003.

Amended Regulation 4-7-2 Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts And Services In Colorado

Section 1 Authority

This rule is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-16-109, C.R.S.

Section 2 Purpose

The purpose of this regulation is to provide reasonable standards for the terms and provisions contained in Health Maintenance Organization's (“HMOs”) benefit contracts and evidences of coverage.

Section 3 Applicability and Scope

This regulation shall apply to all HMOs that are required to obtain or maintain a certificate of authority in this state. This regulation shall apply to all benefit contracts and evidences of coverage that are issued or renewed on or after the effective date of this regulation, In the event of conflict between the provisions of this regulation and the provisions of any earlier regulation issued by the Commissioner, the provisions of this regulation shall be controlling as to HMOs.

Section 4 Definitions

No contract or evidence of coverage delivered or issued for delivery to any person by an HMC required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below and in § 10-16-102, C.R.S. unless such definitions comply with the requirements of this section. Definitions other than those set forth herein and in § 10-16-102, C.R.S. may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and for the purpose of any terms used in a benefit contract of evidence of coverage:

A. “Copayment” means the predetermined amount, whether stated as a percentage or a fixed dollar, an enrollee must pay, to receive a specific service or benefit.

B. “Deductible” means the amounts to be paid by the enrollee for covered services, other than a co- payment, before the enrollee is entitled to benefits from a health benefit plan.

C. “Emergency services” means health care services provided in connection with any event that

a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

D. “Group” means a) a bona fide employer covering employees of such employer for the benefit of persons other than the employer; b) an association, including a labor union, which has a constitution and bylaws and which is organized and maintained in good faith for purposes other than that of obtaining insurance; or c) a business group of one (does not include a business group of one that lawfully elects an individual health plan).

E. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

F. “Group contractholder” means the person to which a group contract has been issued.

G. “HMO service area” means the geographical area within which the HMO is authorized to provide or arrange for health care services that are available and accessible to enrollees and may include contracted providers physically located across state or county lines.

H. “Individual contract” or “nongroup contract” means a contract for health care services issued to and covering an individual or a family that is not a group.

I. “Out-of-area services” means the health care services that an HMO covers when its enrollees are outside of the enrollee service area.

J. “Point-of-service plan contract” means a Health Maintenance Organization contract which includes coverage for both in-network services and coverage for services provided by non-contracted providers. The term “point-of-service plan contract” shall also apply to a plan contract where the indemnity coverage or service is underwritten by a non-HMO carrier in this state and is offered in conjunction with an HMO contract.

K. “Primary care physician” means a physician designated by the enrollee, subject to the policies and procedures of the HMO, who supervises, coordinates, and provides initial and basic care to members, initiates their referral for specialist care and maintains continuity of patient care.

L. “Subscriber” means the. individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

M. “Supplemental health care services” means any health care services other than basic health care services as defined in § 10-16-102(5), C.R.S.

N. “Temporarily absent” means circumstances where the enrollee has left the HMO's service area but intends to return within a reasonable period of time, such as a vacation trip.

O. “Urgently needed services” means covered services which enrollees require in order 1o prevent a serious deterioration in their health while they are temporarily absent from the enrollee service area.

P. “Variable Copayment” means a copayment that varies based on the enrollee's use of certain providers.

Q. “Variable Deductible” means a deductible that varies based on the enrollee's use of certain providers.

Section 5 Requirements for Benefit Contracts and Evidences of Coverage

Each enrollee shall be entitled to receive an individual contract and/or evidence of coverage. Each group contractholder shall be entitled to receive a group contract and/or evidence of coverage. Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to enrollees or group contractholders within a reasonable time after enrollment, but not more than fifteen working days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment. The contract and/or evidence of coverage shall include the following:

A. HMO Information

The contract and/or evidence of coverage shall contain the name, address and telephone number of the HMO and shall describe how services may be obtained. A toll free or collect call phone number within the service area for calls, without charge to enrollees, to the Ham's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for member services, problems or questions.

B. Entire Contract

The contract shall contain a statement that the contract, evidence of coverage, all applications and any amendments thereto shall constitute the entire agreement between the parties.

C. Term of coverage

The contract and/or evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect and include any applicable waiting periods.

The contract and/or evidence of coverage shall contain the time and date or occurrence upon which coverage will terminate.

D. Benefits and Services within the HMO's Service Area

The contract and/or evidence of coverage shall contain a specific description of benefits and services available within the HMO's service area.

E. Emergency Care Services

The contract and/or evidence of coverage shall contain a specific description of emergency services available twenty-four hours a day, seven days a week, including disclosure of how emergency care services will be accessible within the HMO's service area by affiliated providers and nonaffiliated providers.

F. Out of Area Benefits and Services

The contract and/or evidence of coverage shall contain a specific description of benefits and services available out of the HMO's service area including situations where balance billing could apply, variable deductibles, variable co-payments and notice if individuals may need to travel into the HMO's service area to receive covered health benefits.

G. Cancellation or Termination

The contract and/or evidence of coverage shall contain the conditions upon which cancellation or termination may be effected by the HMO or the enrollee.

H. Renewal

The contract and/or evidence of coverage shall contain the conditions for, and any restrictions upon, the enrollee's right to renewal.

I. Reinstatement

The contract and/or evidence of coverage shall contain the conditions for, and any restrictions upon, the enrollee's right to reinstate.

J. Claims

The contract and/or evidence of coverage shall contain procedures for filing claims that include:

(1) any required notice to the HMO;

(2) if any claim forms are required, how, when and where to obtain and submit them;

(3) any requirements for filing proper proofs of loss;

(4) any time limit of payment of claims;

(5) notice of any requirement for resolving disputed claims including arbitration; and

(6) a statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

K. Complaint System

In compliance with § 10-16-409, C.R.S., the contract and/or evidence of coverage shall contain a description of the HMO's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract. The mechanism for recording complaints shall substantially comply with Colorado Insurance Regulation 6-2-1, 3 CCR 702-6, and shall include the number, amount and disposition of malpractice claims as they relate to the HMO and the providers who provide health care services to the HMO enrollees.

L. Coordination of Benefits

A group contract and/or evidence of coverage must contain a provision for coordination of benefits that shall be consistent with Colorado Insurance Regulation 4-6-2, 3 CCR 702-4. An individual contract/or evidence of coverage may have an “insurance with other insurers provision.” Additionally, an HMO must coordinate benefits with private passenger automobile coverage, as required under § 10-4-709, C.R.S.

M. Point-of-service plan contract

There is no requirement that POS coverage be offered to groups or individuals. However, if an HMO offers a point-of-service plan, it must be offered to all individuals and/or groups that qualify for the point- of-service plan, based upon the HMO's underwriting standards. If the point-of-service plan is offered to a group, it must be offered to all eligible members of that group. Additionally, an employer may set standards as to which employees are

eligible for POS coverage.

1 .Point-of-service plan mandatory contract provisions.

A point-of-service plan contract must, at a minimum:

a. Provide all basic health care services required by law to be provided by an HMO as in-plan coverage services, including emergency and urgent care; and

b. Provide incentives for enrollees to use in-plan covered services.

2. Point-of-service plan optional contract provisions.

A point-of-service plan may:

a. Limit or exclude specific types of services from coverage when obtained out-of-plan;

b. Include annual out-of-pocket limits and annual and/or lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services; and

c. Include those services that an enrollee obtains from a medical provider for which proper authorization or referral was not given.

3. Point-of-service plan limitations.

An HMO is subject to the following requirements:

a. An HMO may not expend more than 20% of its total annual net medical and hospital expenses (net of reinsurance and coordination of benefit recoveries) for indemnity benefits.

b. If compliance with the amount specified in subparagraph a. of this subsection 3 is not demonstrated on the annual health rate filing required by Division of Insurance Regulation 4-2-11, 5(C), 3 CCR 702-4, the commissioner may prohibit the HMO from offering a point-of-service product for new issues or for the renewal of existing contracts until compliance has been demonstrated.

4. An HMO must comply with the form and rate filing requirements contained in statute and regulation. In complying with these statutes and regulations, the HMO will:

a. Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and

b. Provide or arrange for-adequate systems to:

i. Process and pay claims for out-of-plan covered services;

ii. Meet the requirements of a point-of-service product as set by this section; and

iii. Generate accurate financial and regulatory reports on a timely basis in order for the commissioner to evaluate experience with the point-of-service plan and monitor compliance with the point-of-service plan provisions.

5. Disclosure.

All HMO benefit contracts and evidence of coverage must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

a. The method of reimbursement to enrollees, where applicable;

b. Applicable copayments, coinsurance and deductibles;

c. Exclusions;

d. The services that an enrollee is permitted to obtain on an allowed self-referral basis; and

e. Instructions regarding submission of claims for self-referred health care services.

N. Indemnity Benefits

Basic health care services are required to be offered through providers that are contracted or employed by the HMO. Coverage offered by non-contracted providers may be provided on an indemnity basis, as permitted by law.

Section 6 Prohibited Practices

A. Unfair discrimination

No HMO shall unfairly discriminate against any enrollee based on the age, sex, race, color, creed, national origin, ancestry, religion or marital status. However, nothing shall prohibit an HMO from setting rates or establishing a schedule of charges in accordance with relevant actuarial data. No HMO shall expel or refuse to offer a continuation or conversion contract to individual members of a group based on the health status or health care needs of the individual enrollee or member.

Section 7 Services

A. Out-of-Area Services and Benefits

1. Out-of-area services shall be subject to copayment or deductible requirements set forth in Subsection C of Section 8 of this regulation.

2. When an enrollee is temporarily absent from the HMO's service area, an HMO shall provide benefits for reimbursement for emergency care or urgent care services, or, at the HMO's discretion, transportation which is medically necessary and appropriate under the circumstances to return the enrollee to an HMO provider, subject to the following conditions:

a. The condition could not reasonably have been foreseen;

b. The enrollee could not reasonably arrange to return to the HMO's service area to

receive treatment from the HMO's provider;

c. The temporary absence must be for some purpose other than the receipt of medical treatment; and

d. If the HMO requires notification, the HMO is notified as required by the evidence of coverage unless it is shown that it was not reasonably possible to communicate with the HMO in such time limits,

For urgently needed services, the HMO is notified prior to the commencement of care, unless it is shown that it was not reasonably possible to communicate with the HMO in such time limits.

B. Supplemental Health Care Services

In addition to the basic health care services as defined in § 10-16-102(5), C.R.S., an HMO may offer to its enrollees any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

Section 8 Other Requirements

A. Description of Providers

1. An HMO shall provide its enrollees with access to a list of the names and locations of all of its current primary care physicians and hospitals in an enrollee's service area, no later than the time of enrollment or the time the contract and evidence of coverage are issued and .upon request thereafter.

2. Any list of providers shall contain a notice regarding the availability of the listed primary care physicians. Such notice shall be in not less than ten-point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

"Enrolling in (name of HMO) does not guarantee services by a particular provider on this list. If you wish to be sure of receiving care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for (name-of-HMO). Also, we may--add physicians on a periodic basis and will provide you with a listing of newly added doctors in your local area, if you request it. "

B. Description of the Service Area

A HMO shall provide its enrollees with a description of the HMO's service area no later than the time of enrollment or the time the contract and evidence of coverage is issued and upon request thereafter. If the description of the HMO's service area is changed, the HMO shall provide, at such time, a new description of the HMO's service area to its enrollees.

C. Copayments or Deductibles

1. An HMO may require copayments and/or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments and deductibles for basic health care services shall be shown in the contract and/or evidence of coverage or an addendum thereof as a percentage or as a specified dollar amount.

2. Copayments or deductibles can vary by provider as a means of encouraging an enrollee to obtain services from a particular provider.

D. Complaint System

1. A complaint system shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written complaints.

2. An HMO shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include the address and telephone number to which complaints must be directed and shall specify any required time limits imposed by the HMO.

3. The complaint system shall provide for (i) written acknowledgment of complaints and (ii) complaints to be resolved or to have a final determination of the complaint by the HMO complaint system within a reasonable period of time, but not more than ninety days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the HMO and the enrollee. However, the requirements of Division of Insurance Regulation 4-2-7, 3, CCR 702-4, including the sixty (60) day time limit, shall continue to be applicable to complaints regarding failure to pay claims unless there is a reasonable dispute between the parties concerning the claim.

4. Membership may not be terminated solely as a result of filing a complaint against the HMO.

5. If an enrollee's complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any HMO that makes such binding arbitration a condition of enrollment must fully disclose this, requirement to its enrollees in the contract and evidence of coverage.

Section 9 Severability

If any provision of this regulation or the application thereof to any person or circumstance; is for any reason held to be invalid, the remainder of the regulation and the application for such provision to other persons or circumstances shall not be affected thereby.

Section 10 Effective Date

This regulation is hereby amended shall be effective for policies issued or renewed on January 31,2003.

Section 11 History

Originally issued as Regulation 90-6, effective October 1,1990.

Amended Regulation, effective December 1,1992.

Amended Regulation, effective July 1,2000.

Amended Regulation effective January 31, 2003.

Amended Regulation 4-9-2 Credit Insurance

Section 1. Authority

This regulation is promulgated under the authority of §§ 10-1-109,10-10-109(2.5)(c) and 10-10-114,C.R.S.

Section 2. Basis and Purpose

The purpose of this regulation is to implement component rating and provide standards to enforce the provisions of Article 10 of Title 10, C.R.S., regarding all forms of credit insurance.

Section 3. Definitions

A. “Annual Report for credit insurance” shall mean a list of all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state, including the titles of the programs or products or name of the lending institutions affected by the forms (required if marketed, serviced or rated differently).

B. “Credit insurance” means the same as defined in § 10-10-103(2), C.R.S. and includes all insurance written in connection with a loan but does not include insurance written as an isolated transaction on the part of the insurer not related to an agreement or plan for insuring debtors of a creditor.

C. “Credit insurance forms” means policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and other forms issued by the insurer to be delivered or issued for delivery in Colorado.

D. “Disability” is defined as the inability to perform the substantial and material duties of one's own occupation during the first twelve months of disability. After the first twelve months, disability is defined as the inability to perform the substantial and material duties of one's own occupation or any other occupation for which one is reasonably qualified by education, experience or by training obtained prior to the date of disability or by subsequent training at the insurer's option and expense. This definition shall not apply to lump sum disability coverage.

E. “Dismemberment” is defined to include, at a minimum, the actual loss of use of a hand or foot, or

irrecoverable loss of sight of an eye.

F. “Listing of New Policy Forms for credit insurance” shall mean a list of any new policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery in this state including the titles of the programs or products or type of lending institutions (required if marketed, serviced or rated differently) affected by the forms and the effective date the form will be used.

G. “Loss ratio” is defined as incurred losses divided by earned premiums. No expenses, including loss adjustment expenses, may be included as losses in this ratio.

H. “Property” is all property, such as household furnishings, appliances, business furniture and fixtures and effects pledged as collateral or security acquired as a result of a contract that is related to a credit transaction. Such property may not include automobiles, boats, airplanes, recreational vehicles, trucks, and tractors or like vehicles.

I. The “Pro Rata Refund Method “is calculated as 1 multiplied by 2 divided by 3, where 1, 2,and 3 are defined as follows:

1. The original amount of the premium paid for the coverage period.

2. The number of days or months in the coverage period remaining for which the premium was paid.

3. The number of days or months in the initial coverage period covered by the premium.

J. The “Rule of 78” refund method is calculated as the original amount of the premium paid for the period multiplied by the quantity (T) times (T+l), then divided by the quantity (N) times (N+l). “T” is the remaining term of the insurance, commonly measured in months, and “N” is the original term of the insurance, commonly measured in months.

K. The “Rule of Anticipation refund method” means the method in which the refund is equal to the single premium for the remaining originally scheduled amount(s) of coverage for the remaining term of coverage using the table of premium rates and formulas that applied when the coverage being cancelled was written.

Section 4. Multiple Plans of Insurance

If a creditor makes available to the debtors more than one plan of credit insurance applicable to the credit insurance transaction, each debtor must be informed of each plan for which he or she is eligible.

Section 5. Substitution

When a creditor requires insurance as additional security for indebtedness, the debtor stall be given the option of furnishing the required amount of insurance either:

A. Through existing policies of insurance owned or controlled by the debtor; or

B. By procuring and furnishing the required coverage through any insurer authorized to transact insurance business in Colorado.

Section 6. Benefit Standards/Policy Requirements

A. Minimum Insurance Amounts

1. For other than monthly outstanding balance coverage, the amount of credit insurance at any point in the insurance coverage can never bear a lesser percentage to the scheduled outstanding balance than the percentage that the original amount of coverage bears to the initial loan balance.

2. A group certificate or individual policy providing coverage for less than the term of the loan elected (truncated coverage) shall disclose both the term of the insurance coverage and that the insurance will terminate prior to the scheduled maturity date of indebtedness. The termination disclosure shall appear in prominent type on the first page of the group certificate or individual policy. At the time of election of truncated coverage, the debtor shall be provided with written notification that the term of the insurance coverage is less than the scheduled maturity of the loan.

   The notification regarding truncated coverage may be included in the application, enrollment form, notice of proposed insurance, certificate, policy, or any other document provided to the debtor at the time coverage is elected.

B. Coverage Increases

With respect to coverages, such as monthly outstanding balance coverage, that permit increases in the amount of coverage after the initial effective date of the individual policy or group certificate, the suicide exclusion and the preexisting condition exclusion, if any, may be applied separately with respect to each increase in the amount of coverage from the date of and in the amount of the increase. Under no circumstances, however, may a new pre-existing condition limitation or new suicide exclusion be applied to coverage in force immediately prior to such increase in coverage.

C. Cancellation Notice

All individual policies and group insurance certificates must state that the insurance is cancelable at any time during the term of the contract at the debtor's advance written request to the insurer.

D. Actively-At-Work Requirement

Unless specifically included in the rate development, no actively-at-work requirement more restrictive than one requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage may be included in any credit accident and health insurance policy or contract. “Full-time” means a regular work week of not less than thirty hours, for a period of not less than one month. A debtor shall be considered to be actively at work if absent from work due solely to regular days off, holidays or paid vacation.

E. Allowable Restrictions

All exclusions and restrictions included in any credit insurance policy or contract must be considered in determining whether or not the rate will fulfill the loss ratio requirement when rates are determined according to Section 12, B or C of this regulation. In addition, all exclusions and restrictions must be adequately disclosed to the insured.

F. Credit Life Insurance

Except as permitted in Subsection B of this Section 6, a credit life insurance contract must contain no exclusion other than for suicide within one year of the effective date of the insurance in compliance with § 10-7-109, C.R.S., and the incontestability clause as defined in § 10-7- 102(l)(b), C.R.S., unless such additional exclusions are specifically included in the rate development. Under no circumstances, however, may the contract exclude loss due to commercial aviation or foreign travel.

G. Credit Accident and Health Insurance

1. Unless specifically included in the rate development, no credit accident and health policy shall contain a provision excluding or denying a claim for disability resulting from pre-existing conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within *six* months preceding the effective date of the debtor's coverage, and which caused loss within the six months following the effective date of coverage.

2. Except as provided in Subsection G, 1 of this Section 6, credit accident and health policies may contain no exclusions more restrictive than normal pregnancy, elective surgery, intentionally and self-inflicted injury, flight in non-commercial aircraft, or war.

3. Any credit insurance policy that identifies itself as providing coverage in the case of disability shall define disability no more restrictively than the definition included in Section 3, D of this regulation, unless specifically included in the rate development.

4. The policy or certificate shall provide for a daily benefit equal in amount to no less than one-thirtieth of the monthly benefit payable under the policy or certificate.

H. Credit Unemployment Insurance

Credit unemployment insurance policies must clearly define unemployment within the policy and certificate and must contain provisions not less favorable to insured debtors than the following:

1. Coverage for unemployment for any reason, except that coverage may be excluded for unemployment due to the insured debtor's:

   Voluntary forfeiture of salary, wage or other employment income;

   a. Resignation;

   b. Retirement;

   c. General strike;

   d. Illegal walkout;

   e. War;

   f. Separation from the military;

   g. Willful misconduct or criminal misconduct or unlawful behavior; and

   h. Disability caused by injury, sickness or pregnancy.

2. For credit unemployment insurance which provides for a monthly benefit in the event of unemployment, benefits must start after a waiting period of not longer than thirty (30) days, but need not be retroactive to the first day of unemployment and must have a maximum benefit period that is no shorter than one month. Coverage may include unemployment under the Federal Family Medical Leave Act 29 USC 2602 et., seq.

3. Credit unemployment insurance policies may not contain eligibility requirements more than the following:

a. Exclusion from qualification for coverage: 1) self-employed individuals; 2) workers in seasonal or temporary jobs designed to last six (6) months or less; and 3) debtors who have been notified at the time of election of coverage either orally or in writing of any layoff from employment within the next sixty (60) days. These exclusions must be disclosed to all prospective insureds, if applicable.

b. No employment requirement shall be more restrictive than one requiring that the debtor actually be at work and employed in a full-time gainful occupation on the effective date of coverage and for at least six (6) consecutive months prior to the effective date of coverage.

I. Credit Property Insurance

1. Where premiums are collected on a single premium basis, the premium charge for credit property insurance shall be calculated based on the total replacement value or original amount of indebtedness, whichever is less, of each item of insured property. Premium calculations must be based on purchases of durable goods only and shall not include the cost of any service, meals, entertainment., or any other non-durable item.

2. Coverage shall be not less than that provided by the standard fire policy with coverage attachment, extended coverage endorsement and replacement cost provision endorsement, or such other appropriate standard policy form for the underlying risk and hazard.

3. If the debtor has or obtains additional personal property coverage, the debtor may retain the additional coverage or may substitute coverage at any time and, upon such substitution, shall be entitled to a refund of the unearned premium on the policy Where this insurance was not initially required by the creditor, the debtor may cancel as: any time and shall be entitled to a refund of any premium paid. If such substitution or cancellation occurs within thirty (30) days of the extension of credit, the entire premium shall be refunded, provided that a compensable claim does not occur prior to the date substitution or cancellation occurs.

4. Valuation of losses shall be the replacement cost of the property up to the original amount of indebtedness.

5. “Property” shall be defined no more restrictively than the definition of Section 3, H of this regulation.

6. Coverage may be issued only as long as compliance with § 5-4-301(3), C R.S., is maintained.

J. Credit Dismemberment Insurance

Any credit insurance policy, which identifies itself as providing coverage against dismemberment, shall define dismemberment no more restrictively than the definition included in Section 3, E of this regulation.

Section 7. Premium Payment

A. Single Premium Basis

If the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of the indebtedness, and makes any direct or indirect finance, carrying, credit or service charges whatever to the debtor in connection with such insurance charge or premiums, the

creditor has loaned the premium or the insurance charge to the debtor. This loaned premium will be deemed collected by the insurer as soon as it is added to the indebtedness. In this event, the coverage is deemed to be on a single premium basis. However, credit insurance issued in connection with a covered loan cannot be financed, either directly or indirectly. A “covered loan” is defined in § 5-3.5-101(2), C.R.S.

B. Monthly Basis

A creditor may remit and an insurer may collect on the monthly basis if the insurance charge or premium is not added to the initial amount financed and does not constitute part of the initial outstanding indebtedness, and if no direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with the insurance charge or premium.

Section 8. Termination of Coverage

A. Continuation of Coverage - Group Insurance

If the debtor is covered by a group credit insurance policy and has paid a single premium for the coverage, then, in the event of termination of the group policy for any reason, insurance coverage shall be continued for the entire period for which the single premium has been paid. This provision shall not limit the debtor's right to cancel the insurance at any time at the debtor's written request, nor shall it prevent cancellation of insurance as permitted by Section 8, D.

B. Extension of Coverage - Group-Insurance

If a debtor is covered by a group credit insurance policy providing for the payment of premiums by the insured on a basis other than single premium, then the policy shall provide that, in the event of termination of such group policy for whatever reason, a written termination notice shall be given to the insured debtor at least thirty (30) days prior to the effective date of the termination. This thirty (30) day notice is not required if the existing insurer replaces coverage in the same or greater amount without a lapse of coverage, or if another insurer charging the same or lower premium rate replaces coverage in the same or greater amount without a lapse in coverage.

C. Cancellation of Individual Policies

If a debtor is covered by a contract of individual credit insurance, neither the insurer nor the creditor may cancel the policy without the debtor's express written consent. However, this prohibition is not applicable in the following situations:

1. Non-payment of premium, subject to the insurance contract's mandatory grace period; or
2. Default on the scheduled loan payments; or
3. The creditor no longer has an insurable interest in the debtor (such as duo to a pre-payment of the loan); or
4. For open-end coverage on open-end loans, the insurer may non-renew the coverage by giving notice of its intent to non-renew thirty (30) days prior to the renewal date.

D. Cancellation of Group Certificates

If a debtor is covered by a group certificate and has the collateral legally reposed, the certificate coverage shall terminate on the date of the repossession.

Section 9. Refunds

A. Refund Methodology

1. Except as otherwise permitted in Subsection 9, A, 2, the amount of premium shall not be less than that calculated using the Rule of Anticipation Refund Method.

2. Alternative methods in specified instances.

a. Actuarial Refund Method. Actuarial Refund Method means the method in which the refund is equal to A multiplied by B, divided by C, where: A =: the premium paid for the total coverage originally scheduled, B = the sum of the originally scheduled amounts of insurance for each month in the term of insurance following the date of termination, and C = the sum of the amounts of insurance for each month in the term of coverage originally scheduled. The Actuarial Refund Method may be used for all types of credit life insurance and credit property insurance.

b. Rule of 78 (sum of the digits) Refund Method. The Rule of 78 Refund Method may be used for credit life insurance in which the amount of coverage decreases by approximately the same amount each month, and the amount of coverage in the final month is equal to or less than the approximate amount by which coverage decreases each month.

c. Pro-rata Refund Method. The Pro-rata Refund Method may be used for all credit insurance in which the amount of coverage remains level throughout the entire duration of the coverage.

d. Mean Method. The Mean Method is the average of the Sum of Digits Refund Method and the Pro-rata Refund Method and may be used for credit accident and health insurance and credit unemployment insurance in which the maximum total indemnity amount decreases by a uniform amount each month throughout the term of coverage and the amount of indemnity in the final month of coverage is equal to or less than the amount by which the maximum total indemnity amount decreases each month.

B. Partial Month Calculation

In the event that the insurer is using a refund methodology that requires the use of complete months, no charge for credit insurance may be made for a partial month of fifteen (15) days or less. A full month may be charged for sixteen (16) days or more of a loan month.

C. Minimum Refund

No refund of less than or equal to $5.00 must be made.

D. Involuntary Prepayment of Indebtedness

If an indebtedness is prepaid by the proceeds of one distinct benefit type of the credit insurance policy or policies covering the debtor, then it shall be the responsibility of the insurer issuing another kind of coverage, upon notification by the creditor or by the insurer if the insurer issued additional kinds of insurance, that the indebtedness has been paid off and to refund the unearned premium, if any. The refund must be calculated according to the acceptable methodologies of this Section 9, and must be paid or credited to the debtor, the beneficiary named by the debtor other than the creditor, or to the debtor's estate, as appropriate. For example, if the indebtedness is

prepaid by the proceeds of a life insurance policy or benefit, the unearned premium of the accident and health, unemployment, and property benefits or policies must be refunded.

E. Voluntary Prepayment of Indebtedness

If a debtor prepays the indebtedness other than through the proceeds of a credit insurance policy, all credit insurance policies or distinct benefits covering the indebtedness shall be terminated and a refund of the unearned premium shall be paid or credited to the debtor. However, if a claim under such coverage is in progress at the time of prepayment, the claim shall continue as if there had been no prepayment. Under this circumstance, no refund of unearned credit insurance premium should be made until the claim has been finalized and the refund for that coverage shall be calculated from the date the event or occurrence giving rise to the claim ended.

F. Refund of Creditor Contribution to Payment of Premium

If a creditor pays, from the creditor's own funds, a portion of the premium for any coverage for which an unearned premium refund becomes payable, the insurer may pay to the creditor and the creditor may retain an amount of the refund for the coverage that is equal to the refund as calculated in Section 9 of this regulation, multiplied by the proportion of the total premium paid by the creditor to the total amount of premium originally paid for the coverage.

Section 10. Claims

A. Responsibility of the Insurer

Section 10-10-108(2)(d), C.R.S., requires that the policy or certificate “state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.” Proper payment of the entire claim is the contractual responsibility of the insurer and the simple act of forwarding a check for the entire claim to the creditor cannot relieve the insurer of this responsibility where excess fund exist.

B. Claims Processing

1. For policies and certificates which provide for a maximum amount of insurance, if 1) the debtor becomes insured for an amount in excess of the stated maximum, or 2) two or more individual policies or group certificates are issued in error and an insurance charge or premium has been separately paid by the debtor, then the total amount insured under each individual policy or certificate must be paid in the event of a valid claim. If the error is discovered prior to the incurrence of a claim, the insurer may notify the debtor, refund the excess premium paid and correct or cancel the excess coverage.

2. Except when the scheduled termination of the insurance coverage is more than thirty (30) days before the scheduled termination of the indebtedness, all polities and certificates shall provide for an extension of the maturity date to coincide with the end of the payment period, when the debtor is not obligated to begin monthly payments to the creditor on the effective date of the loan.

   For listings of new policy forms for credit insurance, that to the best of the officer's knowledge, the documents identified on the Listing of New Policy Forms or Annual Report provide all applicable mandated benefits and are in full compliance with all Colorado Insurance Laws and Regulations.

7. The name and title of the officer signing the certification form and the date the certification form is signed;

8. The original signature of the officer. Signature stamps, photocopies or signatures on behalf of the officer are not acceptable.

C. Evidence of Coverage

All credit insurance shall be evidenced by an individual policy, or in the case of group insurance, by a certificate of insurance. It is the responsibility of the insurer that these policies or certificates are provided to the debtor.

Section 12. Rates

With the exception of the use of component based rates as permitted in Section 12, B of this regulation, the maximum permissible premium rates for credit insurance must be filed concurrent with the effective date with the Commissioner. An insurer may at any time use rates lower than those that are filed.

A. Credit Insurance Directly Written by a State or National Bank

All credit insurance written directly by a state or national bank may, at the insurer's option, be rated by either of the methods described in Subsection B and D of this Section 12. However, if the insurer chooses to rate according to Subsection D of this Section 12, the insurer must file, with the Division of Insurance, a listing of the policy forms for which the rates will be determined according to Subsection D of this Section 12. This filing must be submitted to the Division of Insurance prior to any use of the rates.

B. Component Rates

As permitted by § 10-10-109(2.5)(c)(I), rates for certain benefits and types of business have been established by the Commissioner after giving due consideration to the individual components listed in that section of law. With the exception of the exemptions provided by Subsection A and C of this Section 12, and Appendix 1 of this regulation, all insurers must use premium rates which are no higher than the rates listed in Appendix 1.

An insurer may at any time use rates lower than those rates listed in Appendix 1. The rates in Appendix 1, when used in accordance with the provisions of this Section 12, B, are deemed to be reasonable in relation to the benefits provided and are not excessive, inadequate nor unfairly discriminatory.

The rates for the specific plans included in Appendix 1 are subject to the following maximum conditions:

1. Credit life insurance may contain no exclusions other than those listed in Section 6, F of this regulation.

2. Credit insurance may include an age restriction providing that no insurance need to be offered to debtors over 65 on the effective date or over 66 on the scheduled maturity date of the debt. In the case of loans, such as revolving credit loans, which have no scheduled maturity date of the debt, credit insurance must be offered to all debtors not older than the attained age of 66. The premium rate to all debtors eligible for coverage shall be the same regardless of age. Coverage may be terminated upon the debtor's attainment of a specified age not less than 66.

3. Credit accident and health insurance may contain no exclusions other than those listed in Section 6, G of this regulation.

4. Credit property insurance must cover all perils excluding theft without evidence of forced entry.

5. The rates for credit life insurance and credit disability insurance do not apply to credit union accounts.

C. Rating for Other Benefits

Rates for benefits and plans which are materially different than those listed in Subsection B of this Section 12, must be rated in accordance with the loss ratio standard of Subsection D of this Section 12. In determining whether a particular benefit or plan is materially different from the plans listed in Subsection B of this Section 12, the commissioner will give consideration to such justification as the insurer may submit. Such justification may include, but need not be limited to the following: The amount of the benefit in relation to the amount of the insured loan balance, the use or nonuse of exclusionary or retroactive waiting periods, the age of the debtor or debtors, the degree of underwriting used, the coverage or exclusion of causes of loss, or the coverage of risks other than those set forth in this regulation.

D. Loss Ratio Standard

All rate or rating plan filings subject to Subsection D of this Section 12, must demonstrate compliance with the 40% loss ratio standard and must be certified by a qualified actuary.

In evaluating such filings, the Commissioner will give consideration to such justification as the insurer may submit. Such justification may include, but need not be limited to, relevant available mortality, morbidity, bodily injury, or unemployment data pertaining to the debtors of a creditor or a class or classes of debtors of a creditor or creditors, previous experience of the same or similar plans of insurance or group of creditors, debtors, or an analysis of the credibility of such data. Use of the credibility standard as promulgated or produced by the National Association of Insurance Commissioners (NAIC) are expressly permitted, but not required.

The benefits provided to Colorado policy and contract holders by the coverage must be reasonable in relation to the premium rates charged and must be such that the 40% loss ratio standard of § 10-10-109(2.5)(b), C.R.S., may be reasonably expected to be met or exceeded. Rates and rating data for all benefit types must accurately reflect the benefits provided

Separate rates by age are allowable.

1. Coverage may be limited to debtors aged 65 and younger or age 66 on the scheduled maturity date of the indebtedness.

2. In the case of open-ended loans, coverage must be provided or offered to all debtors not older than attained age 65, and coverage may be canceled or reduced upon attainment of not less than age 66 by giving notice thirty (30) days prior to such cancellation or reduction.

All rate filings must be accompanied by adequate supporting documentation, which shall include, at a minimum:

1. Experience of earned premiums, incurred losses and calculated loss ratios for the prior three years, or all available experience, if less than three (3) years. Rates and rating data must be based on Colorado data to the extent that it is credible.

2. Target or expected loss ratio.

3. Quantification of any benefit changes.

4. Rate development

5. Analysis of credibility, and use of collateral data such as company experience in other states for similar policies, industry experience, mortality tables or morbidity tables.

6. Demonstration of compliance with the loss ratio standard.

7. Certification of a qualified actuary.

Section 13. Compliance

Credit insurance rated according to Subsection D of this Section 12 of this regulation, is generally required to separately satisfy the loss ratio requirement for each type of coverage or plan, e.g., life, accident and health, property and unemployment. However, experience for a combined coverage, which is sold as a single product for a combined, indivisible premium, may separately satisfy the loss ratio requirement. If the cumulative loss ratio for all Colorado business rated according to Subsection D of this Section 12 and issued or renewed by the insurer for a consecutive three year calendar year period falls below the minimum loss ratio as defined in § 10- 10-109, C.R.S., the insurer shall either promptly file adjusted rates that can be prospectively expected to produce a loss ratio greater than or equal to the minimum standards, or submit reasons acceptable to the Commissioner as to why it should not be required to do so.

If the Commissioner, by the insurer's failure to maintain the required minimum loss ratio, determines that a delinquency of an insurer exists under the provisions of § 10-3-401 et. seq., C.R.S., the insurer shall justify its past practice and provide to the Commissioner an explanation, or plan of abatement or correction. Corrective measures, which the Commissioner may accept in a plan of abatement or correction, may include:

1. Implementation of a rate decrease or benefit increase such that the premiums collected within the following two (2) calendar years will generate a future loss ratio in excess of the statutory minimum, and such that the cumulative five (5) year loss ratio at the end of this two year period will be at least equal to the minimum statutory loss ratio.

2. Payment of a stipulated settlement to the Division of Insurance equal to one hundred and ten percent of the premiums collected in excess of the premium necessary to generate the minimum loss ratio.

3. Refund of any premiums collected in excess of the premium necessary to generate the past minimum loss ratio, such refund to be paid to or applied to the benefit of the insured debtors.

4. Voluntary suspension of credit insurance sales.

Section 14. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanction(s) allowed by law, including, without limitation, any one or more of the following: civil penalties, fines, license suspension, or license revocation.

Section 15. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any

reason held invalid, the remainder of this regulation shall not be affected thereby.

Section 16. Effective Date

This regulation shall become effective on December 1,2002.

Section 17. History

1. New Regulation 74-1 effective March 15,1974.
2. Amended effective December 22,1975.
3. Amended effective July 1,1979.
4. Amended effective January 1,1985.
5. Regulation 74-1 was renumbered 4-9-1, effective June 1,1992.
6. Regulation 4-9-1 was repealed effective October 9,1992.
7. New Regulation 4-9-2, effective October 9,1992.
8. Amended effective April 1,1993.
9. Amended effective November 1,2000.
10. Amended effective December 1, 2002.

Appendix 1

All Rates Listed in Section 1 through 9 are for Single Life Coverage.

1. **Single Premium Life Insurance - Not for use by Credit Union Accounts**

    A. **Gross decreasing term coverage:** The rate is $0.38 per $100 per year.

    B. **Net decreasing term coverage:** The rate is the sum of the component based Monthly Outstanding Balance Life Insurance rate for All Other as in 2.B. below, applied to the amount of coverage in force during each month.

    C. Truncated coverage: The rate is the sum of the component based Monthly Outstanding Balance Life Insurance rate for All Other as in 2.B. below, applied to the amount of coverage in force during each month.

    D. **Level Term coverage:** The component based rate is $0.71 per $100 per year.

2. **Monthly Outstanding Balance Life Insurance** - Not for use by Credit Union Accounts

    A. **Revolving charge accounts:** The component based rate is $0.59 per $1,000 per month.

    B. **All other:** The component based rate is $0.59 per $1,000 per month.

3. **Level Monthly Premium Decreasing Term Life Insurance - not for use by Credit Union Accounts**

A. Gross coverage: Rates per $1,000 initial balance by

number of years:	
Years	Rate
1	0.33
2	0.33
3	0.34
4	0.35
5	0.36
6	0.37
7	0.38
8	0.39
9	0.40
10	0.41

B. Net coverage: Rates per $1,000 initial balance by number of years:	
Years	Rate
1	0.34
2	0.34
3	0.35
4	0.37
5	0.38
6	0.40
7	0.41
8	0.42
9	0.44
10	0.45

C. **Truncated coverage: Net Pay Truncated coverage rates are as follows:**

Term (Yrs)	lYr	2Yr	3Yr
1	0.34		
2	0.47	0.34	
3	0.51	0.43	0.35
4	0.54	0.48	0.42
5	0.55	0.50	0.46
6	0.56	0.52	0.49
7	0.56	0.54	0.51
8	0.57	0.54	0.52
9	0.57	0.55	0.53
10	0.57	0.56	0.54

4. Single Premium Disability Insurance - Not for use by Credit Union accounts

A. 14 day retroactive coverage

B. 30 day retroactive coverage

C. 14 day non-retroactive coverage

D. 30 day non-retroactive coverage

Months	14 Retro	14 Non-Retro	30 Retro
6	1.46	0.81	1.05
12	1.78	1.13	1.38
24	2.43	1.78	2.03
36	3.08	2.43	2.67
48	3.48	2.84	3.08
60	3.81	3.16	3.40
72	4.13	3.48	3.73
84	4.46	3.81	4.05
96	4.78	4.13	4.37
108	5.10	4.46	4.70
120	5.43	4.78	5.02

5. **Monthly Premium Disability Insurance (premium base = sum of remaining payments') - Not for use by Credit Union Accounts**

A. Duration specific rates

1. 14 day retroactive coverage

2. 30 day retroactive coverage

3. 14 day non-retroactive coverage

4. 30 day non-retroactive coverage

B. Composite term rate

Months	14 Retro	14 Non-Retro	30 Retro
6	4.17	2.31	3.01
12	2.74	1.74	2.12
24	1.94	1.43	1.62
36	1.66	1.31	1.44
48	1.42	1.16	1.26
60	1.25	1.04	1.12
72	1.13	0.95	1.02
84	1.05	0.90	0.95
96	0.99	0.85	0.90
108	0.94	0.82	0.86
120	0.90	0.79	0.83

1. 14 day retroactive coverage

2. 30 day retroactive coverage

3. 14 day non-retroactive coverage

4. 30 day non-retroactive coverage

14 Retro	14 Non-Retro	30 Retro	30 Non-Retro
1.49	1.18	1.29	0.95

6. **Monthly Premium Disability Insurance (premium base = remaining principal balance) - Not for use by Credit Union Accounts.**

A. Duration specific rates

1. 14 day retroactive coverage

2. 30 day retroactive coverage

3. 14 day non-retroactive coverage

4. 30 day non-retroactive coverage

B. Composite term rate

1. 14 day retroactive coverage

2. 30 day retroactive coverage

3. 14 day non-retroactive coverage

4. 30 day non-retroactive coverage

Months	14 Retro	14 Non-Retro	30 Retro
6	4.26	2.37	3.08
12	2.85	1.81	2.20
24	2.09	1.53	1.74
36	1.84	1.46	1.60
48	1.63	1.32	1.44
60	1.47	1.22	1.32
72	1.38	1.16	1.24
84	1.31	1.12	1.19
96	1.27	1.10	1.16
108	1.24	1.08	1.14
120	1.22	1.08	1.13

14 Retro	14 Non-Retro	30 Retro	30 Non-Retro
1.69	1.34	1.47	1.08

7. Single Premium Unemployment Insurance - 30 **Day** Retroactive. 6 Month Benefit

A. Without coverage for family leave: .94 per $ 100 initial gross indebtedness per year.

B. With coverage for family leave: $2.14 per $100 initial gross indebtedness per year.

C. 90-day lump sum benefit: $2.66 per $ 100 initial gross indebtedness per year.

8. Monthly Outstanding Balance Unemployment Insurance - 30 Day Retroactive, 6 Month Benefit

A. Without coverage for family leave:

$1.62 per $1,000 of remaining principal balance, $1.37 per $1,000 of remaining payments.

B.With coverage for family leave:

$1.78 per $1,000 of remaining principal balance, $1.51 per $1,000 of remaining payments.

C.90-dav lump sum benefit:

$2.22 per $1,000 of remaining principal balance, $ 1.88 per $1,000 of remaining payments.

9. Property - Dual Interest

A. Single premium:

$2.18 per $ 100 Initial Gross Indebtedness per year.

B. Monthly outstanding balance:

$3.35 per $1,000 of remaining principal balance, $2.85 per $1,000 of remaining payments.

10. Joint Life Factors for Life and Disability Coverages

A. Life and disability coverages may be offered on a joint life basis. The component based rate for joint lives, for the life insurance coverage listed in section 1,2 and 3, is obtained by multiplying the listed single life rate by 1.65.

B. The component based rate for joint lives, for the disability insurance coverages listed in Section 4., 5., and 6., is obtained by multiplying the listed single life rate by 1.75.