Addendum: for use with Colorado Health online ExamFX courses and study guides version #20922en (Health), per exam content outline updates effective 1/1/2020.

*The following are **content additions** to supplement your existing text unless otherwise indicated:*

Colorado Statutes, Rules, and Regulations for Sickness & Accident Insurance Only

C. Group Coverage

2. Mental Health

Carriers that offer behavioral, mental health, and substance use disorder treatment must also cover

- An unhealthy alcohol use screening for adults, which must be provided without deductibles, copayments or coinsurance;
- A preventive screening for depression in adolescents and adults, which must be provided without deductibles, copayments or coinsurance; and
- Perinatal maternal counseling for persons at risk, which must be provided without deductibles, copayments or coinsurance.

These benefits may be provided by a primary care provider, behavioral health care provider, or a licensed or certified mental health professional.

D. Small Group Coverage

2. Guaranteed Issue, Open Enrollment, and Special Enrollment

Carriers offering individual health benefit plans **must accept every eligible individual** who applies for coverage and who agrees to make the required premium payments and abide by the reasonable provisions of the plan. However, carriers may choose to restrict enrollment to open or special enrollment periods.

Carriers offering individual health benefit plans must display continuously and prominently on their web site:

- Notice of open enrollment dates;
- Notice of special enrollment for qualifying and triggering events;
- Notice of the enrollment periods for each qualifying and triggering event; and
- Instructions on how to enroll.

3. Rating Factors

Colorado law defines **case characteristics** as demographic characteristics that carriers consider when determining premium rates for individuals and small employers. Case characteristics are limited to the following demographic characteristics:

- The age of covered individuals;
- Geographic location of the policyholder;
- Family size; and
- Tobacco use.

E. Specified Products

1. Medicare Supplement

The design and content of an advertisement of a Medicare supplement insurance policy must be complete and clear enough to avoid deception or the capacity or tendency to mislead or deceive.

Advertisements must be truthful and not misleading in fact or in implication. Words or phrases whose meanings are clear only by implication or by the consumer's familiarity with insurance terminology may not be used.

2. Long-Term Care

Utilization Review

Colorado established guidelines for insurer compliance in situations involving utilization review and certain denials of long-term care insurance benefits. Insurers are required to do the following:

- Adopt and implement reasonable standards for the prompt investigation of claims arising from long-term care policies;
- Promptly provide a reasonable explanation of the basis in the long-term care 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.

Insurers must determine coverage and notify the covered person and the covered person's facility and/or health care professional of the determination within **15 calendar days** of the insurer's receipt of the request.

This time limit may be extended once for up to 15 days provided the insurer

- Determines that an extension is necessary due to matters beyond the insurer's control; and
- Notifies the covered person BEFORE the expiration of the initial 15 calendar day time period of the circumstances requiring the extension of time and the date by which the insurer expects to make a determination.

If an extension is necessary due to the failure of the covered person to submit necessary information, the notice of extension must

- Specifically describe the required information necessary to complete the request; and
- Give the covered person at least 45 calendar days from the date of receipt of a notice to provide the specified information.

If a **claim is denied**, the insurer must notify the covered person and provide

- An explanation of the specific medical basis for the adverse determination;
- The specific reason or reasons for the adverse determination;
- Reference to the specific policy provisions on which the determination is based;
- 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;
- If the insurer relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, that information must be disclosed, and the insurer must provide any of those upon request from the covered person;
- If the adverse determination is based on a medical necessity or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the long-term care policy 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;
- Information sufficient for the covered person to be able to identify the claim involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A description of the insurer's review procedures and the time limits applicable to such procedures; and
- An explanation of the right of the covered person to appeal an initial adverse determination with a description of the procedures for requesting an appeal.