

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-35

REQUIRED INFORMATION FOR CARRIERS TO PROVIDE ON EXPLANATION OF BENEFITS FORMS

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Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-137(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to set forth the minimum required information for carriers to provide on an explanation of benefits form sent to covered persons.

Section 3 Applicability

The requirements and provisions of this regulation apply to health benefit plans, limited benefit health coverage, short-term limited duration health insurance policies, and dental plans issued or delivered on or after the effective date of this regulation.

This regulation does not apply to Medicare Supplement or disability income insurance.

Section 4 Definitions

- A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.
- B. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.
- C. "Health benefit plans" shall have the same meaning as found at § 10-16-102(32), C.R.S.
- D. "Limited benefit health coverage" means, for the purposes of this regulation, any type of health coverage that is not provided by a health benefit plan, as defined in § 10-16-102(32)(a), C.R.S.
- E. "Protected health information" means, for the purposes of this regulation, 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.

Section 5 Explanation of Benefits Form Information

Carriers shall include the following information on an Explanation of Benefits (EOB) form sent to covered persons:

- A. Name of member.
- B. Relationship of member to subscriber.
- C. Subscriber/member's claim number.
- D. Name of subscriber.
- E. Provider name and whether the provider is in or out of network.
- F. Date of service.
- G. Type of service (emergency, inpatient, outpatient, etc.).
- H. Denial information (with enough specificity to enable the member/subscriber to determine the reason for the denial). Additionally, the following notice shall accompany the denial:

"Notice: The diagnosis and treatment codes (and their meaning) related to the service that is the subject of this Explanation of Benefits (EOB) are available upon request made to the carrier."
- I. Carrier contact information.
- J. Explanation of appeal rights (Can be an attachment to EOB).
- K. Notice "THIS IS NOT A BILL".
- L. Claim payment calculation.
 1. Financial Information:
 - a. Total billed amount; and
 - b. Amount allowed under the policy (if amount was less than billed amount include explanation: i.e. discounted due to network agreement, carrier's determination of reasonable and customary, out of network provider).
 2. Breakdown of policy's cost-sharing requirements:
 - a. Subscriber/member's deductible amounts;
 - b. Subscriber/member's coinsurance amount or out-of-pocket amounts; and
 - c. Subscriber/member's copayment amounts.
- M. Subscriber/member's financial liability.

1. "What you owe" (deductible + coinsurance + copayment + denied amounts the member/subscriber is liable for); and
 2. "What we will pay".
- N. Status of policy deductible, out-of-pocket amount, and policy maximums.
1. All deductible amounts applied to date;
 2. All coinsurance amounts or out-of-pocket amounts applied to date, if applicable; and
 3. Policy maximum amount, if applicable (annual out-of-pocket maximum or in the case of limited benefit health coverage, any annual limits for a specific benefit).

Section 6 Protected Health Information

For the purpose of an explanation of benefits form, carriers shall take reasonable steps to ensure that the protected health information (PHI) of any covered person is protected. This protection includes ensuring that any communications between the carrier and covered person remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA). This protection of PHI includes, but is not limited to, developing a means of communicating confidentially with the covered person, in such a manner that PHI would not be sent to the primary policyholder without prior consent of the covered person and when the covered person is legally able to provide consent to treatment pursuant to Colorado law. This confidential means of communication shall be made available to the covered person upon request.

Section 7 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 8 Enforcement

Noncompliance with this regulation may result 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 civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation is effective October 1, 2018.

Section 10 History

New Regulation effective October 1, 2011.
Amended Regulation effective January 1, 2014.
Amended Regulation effective October 1, 2018.