10-16-104. Mandatory coverage provisions - definitions - rules

(1) Newborn children. (a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(b)

(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(III) The provisions of subparagraphs (I) and (II) of this paragraph (b) shall not apply in any case in which the decision to discharge the newborn prior to the minimum length of stay otherwise required under subparagraphs (I) and (II) of this paragraph (b) is made by an attending provider with the agreement of the mother.

(IV) Nothing in this paragraph (b) shall be construed to require a mother who is a participant or beneficiary to give birth in a hospital or to stay in the hospital for a fixed period of time after the birth of her child.

(V) Nothing in this paragraph (b) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan; except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subparagraphs (I) and (II) of this paragraph (b) may not be greater than such coinsurance or cost-sharing for any other sickness, injury, disease, or condition that is otherwise covered under the policy or contract.

(c)

(I) Except as provided for cleft lip and cleft palate coverage in sub-subparagraph (A) of subparagraph (II) of this paragraph (c) and for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist pursuant to sub-subparagraph (A) of subparagraph (III) of this paragraph (c), the benefits available to newborn children shall consist of coverage of injury or sickness, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one days of the newborn's life, notwithstanding policy limitations and exclusions applicable to other conditions or procedures covered by the policy. Except as provided in sub-subparagraph (C) of subparagraph (II) of this paragraph (c), such coverage shall be subject to copayment, deductible, and aggregate dollar policy maximums that are no higher than are generally applicable under the policy to all other sicknesses, diseases, and conditions otherwise covered under the policy.

(II) (A) With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

(B) Cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate shall be considered to be compensable for coverage under the provisions of sub-subparagraph (A) of this subparagraph (II).

(C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. Such policy or contract may contain the same copayment provisions for the coverage of cleft lip or cleft palate or both as apply to other conditions or procedures covered by the policy or contract.

(III) (A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.
(C) As used in this subparagraph (III), "medical foods" means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.
(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.
(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.
(e) The requirements of this section shall apply to all individual sickness and accident policies issued on and after July 1, 1975, and to all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1975, and to all subscriber or enrollee coverage contracts delivered or issued for delivery in this state on and after July 1, 1975.
(f)
(I) Any contract of a prepaid dental plan of an entity subject to the provisions of part 5 of this article applied for that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth to the same extent that such coverage applies to other individuals in the family. If payment of a specific premium or capitation amount is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium or capitation amount shall be furnished to the organization within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.
(II) The coverage for newborn children shall include any orthodontics or dental care needed as the result of the child being born with a cleft lip or cleft palate or both. The contract providing such coverage may contain the same copayment provisions as apply to other conditions or procedures covered by the contract.
(g) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.
(1.3) Early intervention services. (a) As used in this subsection (1.3), unless the context otherwise requires:
(I) "Division" means the unit within the department of human services that is responsible for developmental disabilities services.
(II) "Early intervention services" means services as defined by the division in accordance with part C that are authorized through an eligible child's IFSP but that exclude nonemergency medical transportation; respite care; service coordination, as defined in 34 CFR 303.12 (d)(11); and assistive technology, unless assistive technology is covered under the applicable insurance policy or service or indemnity contract as durable medical equipment.
(III) "Eligible child" means an infant or toddler, from birth through two years of age, who is an eligible dependent and who, as defined by the department pursuant to section 27-10.5-702 (9), C.R.S., has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to section 27-10.5-102 (11)(c), C.R.S.
(IV) "Individualized family service plan" or "IFSP" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes early intervention services to an eligible child and the child's family. An IFSP shall serve as the individualized plan, pursuant to section 27-10.5-102 (20)(c), C.R.S., for an eligible child from birth through two years of age.
(V) "Part C" means the early intervention program for infants and toddlers who are eligible for services under part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq.
(VI) "Qualified early intervention service provider" or "qualified provider" means a person or agency, as defined by the division in accordance with part C, who provides early intervention services and is listed on the registry of early intervention service providers pursuant to section 27-10.5-708 (1)(a), C.R.S.
(b)
(I) All individual and group sickness and accident insurance policies or contracts issued or renewed by an entity subject to part 2 of this article on or after January 1, 2008, and all service or indemnity contracts issued or renewed by an entity subject to part 3 or 4 of this article on or after January 1, 2008, that include dependent coverage shall provide coverage

for early intervention services delivered by a qualified early intervention service provider to an eligible child. Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans.

(II) (A) The coverage required by this subsection (1.3) must be available annually to an eligible child from birth up to the child's third birthday for early intervention services for each dependent child per calendar or policy year. The commissioner shall specify, by rule, the extent of the coverage for early intervention services required by this subsection (1.3), which, except for grandfathered health benefit plans, must require coverage of a number of early intervention services or visits that is actuarially equivalent to the dollar limit of the benefit as it existed prior to May 13, 2013.

(B) For grandfathered health benefit plans, the coverage required by this subsection (1.3) per calendar or policy year for early intervention services for each eligible dependent child from birth up to the child's third birthday is limited to six thousand three hundred sixty-one dollars, including case management costs. Effective January 1, 2014, and each January 1 thereafter, the commissioner shall annually adjust the dollar limit for early intervention services coverage based on the Denver-Aurora-Lakewood consumer price index or, if applicable, its predecessor or successor index for the state fiscal year that ends in the immediately preceding calendar year, or by an additional amount equal to the increase by the general assembly in the annual appropriated rate to serve one child for one fiscal year in the state-funded early intervention program if that increase is more than the consumer price index increase.

(III) Except as provided in paragraph (d) of this subsection (1.3), the coverage shall not be subject to deductibles or copayments, and any benefits paid under the coverage required by this subsection (1.3) shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract. Unless the carrier agrees prior to the provision of early intervention services, a carrier shall not be required to pay a reimbursement rate for early intervention services provided by a nonparticipating provider that exceeds the reimbursement rate allowed for comparable early intervention services provided by a participating provider.

(IV) Any limit on the amount of coverage for early intervention services specified by the commissioner by rule pursuant to sub-subparagraph (A) of subparagraph (II) of this paragraph (b) or, for grandfathered health benefit plans, specified in sub-subparagraph (B) of subparagraph (II) of this paragraph (b) shall not apply to:

(A) Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation;

(B) Services provided to a child who is not participating in part C and services that are not provided pursuant to an IFSP. However, such services shall be covered at the level specified in paragraph (b) of subsection (1.7) of this section.

(c) This subsection (1.3) shall not apply to the following:

(I) Short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit health insurance, as defined by the commissioner by rule, credit disability insurance, or a medicare supplement policy as defined in section 10-18-101 (4);

(II) Workers' compensation or similar insurance;

(III) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and required by law to be contained in any liability insurance policy or equivalent self-insurance.

(d)

(I) The coverage required by this subsection (1.3) may be offered through a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223; except that a carrier may apply deductible amounts for the required coverage if it is not considered by the United States department of treasury to be preventive or to have an acceptable deductible amount.

(II) If a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223 requires a deductible or copayment amount for the coverage required by this subsection (1.3), the deductible or copayment amount may be paid by the state as determined by rules adopted by the commissioner in accordance with article 4 of title 24, C.R.S., in consultation with the division of insurance.

(d.5)

(I) Upon notice from the department of human services pursuant to section 27-10.5-709 (1), C.R.S., that a child is eligible for early intervention services, the carrier shall submit payment of benefits for the eligible child in accordance with this subparagraph (I) and section 27-10.5-709 (1), C.R.S. If the eligible child is covered by a grandfathered health benefit plan, the carrier shall submit payment in the amount specified in sub-subparagraph (B) of subparagraph (II) of paragraph (b) of this subsection (1.3), as adjusted annually pursuant to said sub-subparagraph. If the eligible child is covered by any other policy orcontract subject to this subsection (1.3), the carrier shall submit payment in an amount that equals the approximate value of the number of early intervention services or visits specified by the commissioner pursuant to sub-subparagraph (A) of subparagraph (II) of paragraph (b) of this subsection (1.3).

(II) Qualified early intervention service providers that receive reimbursement in accordance with this paragraph (d.5) shall accept the reimbursement as payment in full for services provided under this subsection (1.3) and shall not seek additional reimbursement from either the covered person or the carrier.

(e) Within ninety days after the division determines that a child is no longer an eligible child for purposes of this subsection (1.3), the division shall notify the carrier that the child is no longer eligible and that the carrier is no longer required to provide the coverage required by this subsection (1.3) for that child.

(f) Use of available coverage under this subsection (1.3) for the cost of early intervention services is mandatory, consistent with the requirements of part C. An eligible child must fully utilize available coverage under this subsection (1.3) prior to accessing state general funds or federal part C funds. A carrier shall not terminate or fail to renew health coverage on the basis that an eligible child has accessed or will be accessing early intervention services under this subsection (1.3).

(g) Early intervention services shall be provided as specified in the eligible child's IFSP, and such services shall not duplicate or replace treatment for **autism** spectrum disorders provided in accordance with subsection (1.4) of this section. Services for the treatment of **autism** spectrum disorders provided in accordance with subsection (1.4) of this section shall be considered the primary service to an eligible child, and early intervention services provided under this subsection (1.3) shall supplement, but not replace, services provided under subsection (1.4) of this section.

(1.4) **Autism** spectrum disorders. (a) As used in this subsection (1.4), unless the context otherwise requires:

(I) "Applied behavior analysis" means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

(II) "**Autism** services provider" means any person who provides direct services to a person with **autism** spectrum disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and meets one of the following:

(A) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with **autism** spectrum disorders;

(B) Has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with **autism** spectrum disorders;

(C) Has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization;

(D) Has a master's degree or higher in one of the behavior or health sciences, is credentialed as a related services provider, and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with **autism** spectrum disorders. For the purposes of this sub-subparagraph (D), "related services provider" means a physical therapist, occupational therapist, or speech therapist.

(E) Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a "board certified associate behavior analyst" by the behavior analyst certification board or by a similar nationally recognized organization; or

(F) Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an **autism** spectrum disorder under the supervision of an **autism** services provider described in sub-subparagraph (A), (B), (C), (D), or (E) of this subparagraph (II).

(III) "**Autism** spectrum disorders" or "ASD":

(A) Has the same meaning as set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and

(B) Includes the following disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis: Autistic disorder, Asperger's disorder, and atypical **autism** as a diagnosis within pervasive developmental disorder not otherwise specified.

(IV) "Health benefit plan", does not include:

(A) Short-term limited duration health insurance policies; or

(B) Individual grandfathered health benefit plans.

(V) "Individualized education program" shall have the same meaning as provided in section 22-20-103, C.R.S.

(VI) "Individualized family service plan" shall have the same meaning as provided in section 27-10.5-102, C.R.S.

(VII) "Individualized plan" has the same meaning as provided in section 25.5-10-202, C.R.S.

(VIII) "Pharmacy care" means medications prescribed by a physician licensed by the Colorado medical board under the "Colorado Medical Practice Act", article 36 of title 12, C.R.S.

(IX) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed by the Colorado medical board under the "Colorado Medical Practice Act", article 36 of title 12, C.R.S.

(X) "Psychological care" means direct or consultative services provided by a psychologist licensed by the state board of psychologist examiners pursuant to part 3 of article 43 of title 12, C.R.S., or a social worker licensed by the state board of social work examiners pursuant to part 4 of article 43 of title 12, C.R.S.

(XI) "Therapeutic care" means services provided by a speech therapist; an occupational therapist or occupational therapy assistant licensed to practice occupational therapy pursuant to article 40.5 of title 12, C.R.S.; a physical therapist licensed to practice physical therapy pursuant to article 41 of title 12, C.R.S.; or an **autism** services provider. "Therapeutic care" includes, but is not limited to, speech, occupational, and applied behavior analytic and physical therapies.

(XII) "Treatment for **autism** spectrum disorders" shall be for treatments that are medically necessary. The treatments listed in this subparagraph (XII) are not considered experimental or investigational and are considered appropriate, effective, or efficient for the treatment of **autism**. "Treatment for **autism** spectrum disorders" shall include the following, as medically necessary:

(A) Evaluation and assessment services;
(B) Behavior training and behavior management and applied behavior analysis, includingbut not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for **autism** spectrum disorders provided by **autism** services providers;
(C) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. For a person who is also covered under subsection (1.7) of this section, the level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is medically necessary to treat **autism** spectrum disorders under this subsection (1.4).
(D) Pharmacy care and medication, if covered by the health benefit plan;
(E) Psychiatric care;
(F) Psychological care, including family counseling; and
(G) Therapeutic care.
(XIII) "Treatment plan" means a plan developed for an individual by an **autism** services provider and prescribed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an individual consisting of the individual's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. The treatment plan shall be developed in accordance with the patient-centered medical home as defined in section 25.5-1-103 (5.5), C.R.S.
(b)
(I) All health benefit plans issued or renewed in this state must provide coverage for the assessment, diagnosis, and treatment of **autism** spectrum disorders for a child pursuant to this subsection (1.4).
(II) Nothing in this subsection (1.4):
(A) Requires or permits a carrier to reduce benefits provided for **autism** spectrum disorders if a health benefit plan already provides coverage that exceeds the requirements of this subsection (1.4) and rules adopted by the commissioner;
(B) Prevents a carrier from increasing benefits provided for **autism** spectrum disorders; or
(C) Limits coverage for physical or mental health benefits covered under a health benefit plan.
(c) Treatment for **autism** spectrum disorders shall be prescribed or ordered by a licensed physician or licensed psychologist.
(d) A health benefit plan offered to residents of this state providing basic health care services that is delivered, issued for delivery, or renewed in this state shall not exclude **autism** spectrum disorders or impose additional requirements for authorization of services that operate to exclude coverage for the assessment, diagnosis, and treatment of **autism** spectrum disorders.
(e) Except as otherwise provided in paragraph (b) of this subsection (1.4), the coverage required under this subsection (1.4) shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health benefit plan. The benefits of this subsection (1.4) shall be in addition to any benefits provided for in subsections (1.3) and (1.7) of this section.
(f) Benefits provided by a carrier on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an **autism** spectrum disorder, shall not be applied toward any maximum benefit amount established under this subsection (1.4).
(g) A carrier may not deny or refuse to provide otherwise covered services, refuse to issue, renew, or reissue, or otherwise restrict or terminate coverage under a health benefit plan because the individual or his or her covered dependent is diagnosed with an **autism** spectrum disorder or due to the individual's or dependent's utilization of services for which benefits are mandated by this subsection (1.4).
(h) Any review of a treatment plan or any appeal of a decision regarding treatment shall be subject to the rules of the commissioner on prompt investigation of health plan claims involving utilization review and denial of benefits.
(i) Nothing in this subsection (1.4) shall be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized plan. The services required to be covered by this subsection (1.4) shall be in addition to any services provided to an individual under an individualized family service plan, an individualized education program, or an individualized plan.
(j) Coverage under this subsection (1.4) is subject to all terms, conditions, definitions, restrictions, exclusions, limitations, and utilization review of health care services that apply to any other coverage under the health benefit plan, including the treatment under the health benefit plan of services performed by participating and nonparticipating providers.
(1.5) (Deleted by amendment, L. 2009, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010.)
(1.7) Therapies for congenital defects and birth abnormalities. (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.
(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy

or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.
(c) Repealed.
(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (1.7) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.
(2) Complications of pregnancy and childbirth. (a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract. Any sickness and accident insurance policy providing indemnity for disability due to accident shall provide coverage for an accident which occursduring the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy.
(b) Any sickness and accident insurance policy providing coverage for sickness on an expense-incurred basis shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy.
(3) Maternity coverage. (a) (I) [Editor's note: This version of subparagraph (I) is effective until January 1, 2019.] All group sickness and accident insurance policies providing coverage within the state and issued to an employer by an entity subject to part 2 of this article, all group health service contracts issued by an entity subject to part 3 or 4 of this article and issued to an employer, all individual sickness and accident insurance policies issued by an entity subject to part 2 of this article, and all individual health care or indemnity contracts issued by an entity subject to part 3 or 4 of this article, except supplemental policies covering a specified disease or other limited benefit, shall insure against the expense of normal pregnancy and childbirth or provide coverage for maternity care and provide coverage for contraception in the same manner as any other sickness, injury, disease, or condition is otherwise covered under the policy or contract. Individual sickness and accident insurance policies or contracts may exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition. The exclusion for the pregnancy as a preexisting condition under the policy or contract shall not apply for any subsequent pregnancies. Group sickness and accident insurance policies or contracts shall not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.
(3) Maternity coverage. (a) (I) [Editor's note: This version of subparagraph (I) is effective January 1, 2019.] (A) All group sickness and accident insurance policies providing coverage within the state and issued to an employer by an entity subject to part 2 of this article 16, all group health service contracts issued by an entity subject to part 3 or 4 of this article 16 and issued to an employer, all individual sickness and accident insurance policies issued by an entity subject to part 2 of this article 16, and all individual health care or indemnity contracts issued by an entity subject to part 3 or 4 of this article 16, except supplemental policies covering a specified disease or other limited benefit, must insure against the expense of normal pregnancy and childbirth or provide coverage for maternity care and provide coverage for contraception in the same manner as any other sickness, injury, disease, or condition is otherwise covered under the policy or contract; except that coverage for contraception must be consistent with the requirements in section 10-16-104.2.
(B) Individual sickness and accident insurance policies or contracts may exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition; except that the exclusion for a pregnancy as a preexisting condition under the policy or contract does not apply for any subsequent pregnancies. Group sickness and accident insurance policies or contracts must not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition.
(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.
(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.
(IV) The provisions of subparagraphs (II) and (III) of this paragraph (a) shall not apply in any case in which the decision to discharge prior to the minimum length of stay otherwise required under subparagraphs (II) and (III) of this paragraph (a) is made by an attending provider with the agreement of the mother.
(V) Nothing in this paragraph (a) shall be construed to require a mother who is a participant or beneficiary to give birth in a hospital or to stay in the hospital for a fixed period of time after the birth of her child.
(VI) Nothing in this paragraph (a) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan; except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subparagraphs (II) and (III) of this paragraph (a) may not be greater than such coinsurance or cost-sharing for any other sickness, injury, disease, or condition that is otherwise covered under the policy or contract.
(b) The requirement in paragraph (a) of this subsection (3) shall not apply to policies or contracts purchased by employers who employ any number of full-time or part-time employees in fewer than fifteen full-time employee positions

or to employers who employ any number of full-time or part-time employees for not more than six consecutive months each year on a seasonal basis if such coverage as required in paragraph (a) of this subsection (3) is provided by the employer in one of the following methods:
(I) Self-insurance. All employers who elect under this subparagraph (I) to utilize self-insurance for providing this benefit shall provide written notice to affected employees and to the health insurance carrier of its choice to self-insure.
(II) A policy purchased from an insurance company authorized to do business in this state which meets all of the requirements of the division of insurance for that purpose;
(III) A contract issued by an entity subject to the provisions of part 3 or 4 of this article;
(IV) A combination of the methods of obtaining insurance authorized in subparagraphs (I) to (III) of this paragraph (b).
(c) An entity authorized under the provisions of part 3 or 4 of this article to issue service or indemnity-type contracts shall offer coverage for maternity care to both married and unmarried women in individual, nonfamily contracts and shall offer the same coverage and the same payment of costs for maternity benefits to unmarried women that it offers to married women.
(4) (Deleted by amendment, L. 2009, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010.)
(5) Repealed.
(5.5) Behavioral, mental health, and substance use disorders - rules. (a) (I) Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), must provide coverage for the treatment of both biologically based mental health disorders and behavioral, mental health, or substance use disorders that is no less extensive than the coverage provided for a physical illness.
(II) (Deleted by amendment, L. 2013.)
(III) [Editor's note: This version of subparagraph (III) is effective until January 1, 2019.] Any preauthorization or utilization review mechanism used in the determination to provide the coverage required by this paragraph (a) must be the same as, or no more restrictive than, that used in the determination to provide coverage for a physical illness. The commissioner shall adopt rules as necessary to implement and administer this subsection (5.5).
(III) [Editor's note: This version of subparagraph (III) is effective January 1, 2019.] (A) Except as provided in subsection (5.5)(a)(III)(B) of this section, any preauthorization or utilization review mechanism used in the determination to provide the coverage required by this subsection (5.5)(a) must be the same as, or no more restrictive than, that used in the determination to provide coverage for a physical illness. The commissioner shall adopt rules as necessary to implement and administer this subsection (5.5).
(B) A health benefit plan subject to this subsection (5.5) must provide coverage without prior authorization for a five-day supply of at least one of the federal food and drug administration-approved drugs for the treatment of opioid dependence; except that this requirement is limited to a first request within a twelve-month period.
(IV) As used in this subsection (5.5):
(A) "Behavioral, mental health, or substance use disorder" means post-traumatic stress disorder, substance use disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, general anxiety disorder, and **autism** spectrum disorders, as defined in subsection (1.4)(a)(III) of this section.
(B) "Biologically based mental health disorder" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
(b) The commissioner may adopt rules as necessary to ensure that this subsection (5.5) is implemented and administered in compliance with federal law.
(c) A health care service plan issued by an entity subject to part 4 of this article may provide that the benefits required by this subsection (5.5) are covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.
(6) Dependent children. (a) No entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall refuse to accept and honor an otherwise valid claim for a covered benefit that is filed by either parent of a covered child, or by the state department of human services in the case of an assignment under section 26-13-106, C.R.S., who submits valid copies of medical bills. A claim submitted by a custodial parent who is not the insured under a policy issued by an entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall be deemed a valid assignment of benefits for payment to the health care provider.
(b) An entity described in subsection (6)(a) of this section must not refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that:
(I) The child does not live in the home of the parent applying for the policy; or
(II) The child does not live in the insurer's service area, notwithstanding any other provision of law restricting enrollment to the persons who reside in an insurer's service area; or
(III) The child's parents were not married at the time of his or her birth; or
(IV) The child is not claimed as a dependent on the child's parent's federal or state income tax return.
(c) When a dependent child is enrolled in a health insurance plan of a parent with whom the child resides less than fifty percent of the time, the entity described in paragraph (a) of this subsection (6) shall:
(I) Provide to the dependent child's parent with whom the child resides the majority of the time information that is necessary for the dependent child to obtain medical benefits and services;

(II) Allow the parent described in subparagraph (I) of this paragraph (c), the health care provider with such parent's approval, or the state to submit claims for covered services without the approval of the other parent;
(III) Make payments directly to the parent described in subparagraph (I) of this paragraph (c), the health care provider, or the state medical assistance agency on claims submitted pursuant to subparagraph (II) of this paragraph (c).
(d) Whenever a parent of a dependent child with whom the child resides less than fifty percent of the time is subject to a court or an administrative order to provide health care coverage for the dependent child, and such parent is eligible for family health care coverage through the parent's employment, the entity described in paragraph (a) of this subsection (6) shall:
(I) Permit such parent to enroll the dependent child under the family coverage plan, regardless of any enrollment season restriction;
(II) Enroll the dependent child upon application for enrollment by the parent with whom the child resides the majority of the time, the state medical assistance agency, or the state child support enforcement agency or a delegate child support enforcement unit if the parent with whom the child resides less than fifty percent of the time is enrolled in a family coverage plan but fails to enroll the dependent child, regardless of any enrollment restrictions;
(III) Not cancel or revoke enrollment of the dependent child, or eliminate coverage for the dependent child, unless the insurer is provided with satisfactory written proof that:
(A) The court or administrative order for health care coverage is no longer in effect; or
(B) The child is or will be enrolled in a comparable plan through another insurer, which enrollment takes effect no later than the effective date of the cancellation or revocation of enrollment or the elimination of coverage.
(e) An entity described in paragraph (a) of this subsection (6) shall not impose on the state medical assistance agency that is assigned the right to recover medical costs on behalf of a medical assistance recipient any requirement that is not imposed on or applicable to other agents or assignees.
(6.5) Adopted child - dependent coverage. (a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, regardless of whether adoption of the child is final.
(b) An entity described in paragraph (a) of subsection (6) of this section shall not deny or restrict coverage to an adopted child of an enrollee, policyholder, or subscriber or a child placed for adoption with an enrollee, policyholder, or subscriber on the basis of a preexisting condition if the child would otherwise be eligible for enrollment or coverage and the adoption or placement occurs while the adoptive parent or parent with whom the child is placed is enrolled in the plan.
(c) For the purposes of this subsection (6.5), unless the context otherwise requires:
(I) "Child" means a person who has not attained eighteen years of age.
(II) "Placed for adoption" means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.
(6.7) Medical assistance recipients - denial of coverage - liability to state. (a) No entity subject to the provisions of this article, article 8 of this title, or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall refuse to enroll a person for the sole reason that the person is a medical assistance recipient for whom coverage is sought pursuant to section 25.5-4-210, C.R.S., or refuse to accept and honor an otherwise valid claim for a covered benefit which is filed in the case of an assignment under the provisions of articles 4, 5, and 6 of title 25.5, C.R.S.
(b) An entity subject to this subsection (6.7) that is liable as a third party for the medical costs of a medical assistance recipient or that recovers or may recover medical costs from a third party who is liable to a medical assistance recipient for medical costs is liable to the state pursuant to section 25.5-4-301 (4), C.R.S.
(c) The state is deemed to have acquired the rights as an assignee of the medical assistance recipient to any payment by a third party for medical costs.
(7) Repealed.
(8) Availability of hospice care coverage. (a) As used in this subsection (8), unless the context otherwise requires:
(I) "Home health services" means home health services as defined in section 25.5-4-103 (7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.
(II) "Hospice care" means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103 (1)(a)(I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.
(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary. Nothing in this paragraph (b) shall require an insurer to offer coverages for which premiums would not cover expected benefits. This paragraph (b) shall not apply to any insurance policy, plan, contract, or certificate which provides coverage exclusively for disability loss of income, dental services, optical services, hospital confinement indemnity, accident only, or prescription drug services.

(c) The insurer or entity may adopt standards and criteria for eligibility to be applied to home health services programs and hospice care programs consistent with standards established in rules and regulations of the department of public health and environment.
(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.
(9) Repealed.
(10) Prostate cancer screening. (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. This coverage shall be provided according to the following guidelines:
(I) The screening shall be performed by a qualified medical professional, including without limitation a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant.
(II) The screening shall consist, at a minimum, of the following tests:
(A) A prostate-specific antigen ("PSA") blood test;
(B) Digital rectal examination.
(III) At least one screening per year shall be covered for any man fifty years of age or older.
(IV) At least one screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer as determined by the man's physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article.
(b) The requirements of this subsection (10) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 1996, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 1996.
(c) For purposes of this subsection (10), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as defined in section 10-18-101 (3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.
(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (10) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.
(11) Repealed.
(12) Hospitalization and general anesthesia for dental procedures for dependent children. (a) All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article, except supplemental policies that cover a specific disease or other limited benefit, must provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (17), of a covered person. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:
(I) The child has a physical, mental, or medically compromising condition; or
(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
(III) The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
(IV) The child has sustained extensive orofacial and dental trauma.
(b) A carrier may:
(I) Require prior authorization for general anesthesia and outpatient surgical facilities or hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions; and
(II) Require that if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (12) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the carrier; and

(III) Restrict coverage to include anesthesia provided by an anesthesia provider only during procedures performed by an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

(c) The provisions of this subsection (12) shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

(13) Diabetes. (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall bea participating provider in such managed care plan.

(b) Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

(c) The benefits provided in this subsection (13) are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.

(d) Private third-party payors shall not reduce or eliminate coverage due to the requirements of this subsection (13).

(14) Prosthetic devices. (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(c) A health benefit plan may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

(f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

(15) and (16) Repealed.

(17) Cervical cancer vaccines. (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services.

(b) The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 2008, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 2008.

(c) For purposes of this subsection (17), "sickness and accident insurance policy" does not include short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as described in section 10-18-101 (3) or by the commissioner. The term also does not include insurance arising out of the "Workers' Compensation Act of Colorado", articles 40 to 47 of title 8, C.R.S., or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in a liability insurance policy or equivalent self-insurance.

(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (17) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(18) Preventive health care services. (a) (I) The following policies and contracts that are delivered, issued, renewed, or reinstated on or after January 1, 2010, must provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18):

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to part 2 of this article;

(B) All individual and group health care service or indemnity contracts issued by an entity subject to part 3 or 4 of this article; and
(C) Any other individual or group health care coverage offered to residents of this state.
(II) Repealed.
(III) (A) Except as provided in sub-subparagraph (B) of this subparagraph (III), coverage required by this subsection (18) is not subject to policy deductibles, copayments, or coinsurance.
(B) For purposes of grandfathered health benefit plans, coverage required by this subsection (18) is not subject to policy deductibles or coinsurance. Copayments may apply as required by the grandfathered health benefit plan.
(b) The coverage required by this subsection (18) must include preventive health care services for the following, in accordance with the A or B recommendations of the task force for the particular preventive health care service:
(I) Alcohol use disorder screening and behavioral counseling interventions for adults by primary care providers;
(II) Cervical cancer screening;
(III) (A) One breast cancer screening with mammography per year, covering the actual charge for the screening with mammography.
(B) (Deleted by amendment, L. 2013.)
(C) Benefits for preventive mammography screenings are determined on a calendar year or a contract year basis, which fact must be specified in the policy or contract. The preventive and diagnostic coverages provided pursuant to this subparagraph (III) do not diminish or limit diagnostic benefits otherwise allowable under a policy or contract. If the covered person receives more than one screening in a given calendar year or contract year, the other benefit provisions in the policy or contract apply with respect to the additional screenings.
(D) Notwithstanding the A or B recommendations of the task force, a policy or contract subject to this subsection (18) must cover an annual breast cancer screening with mammography for all individuals possessing at least one risk factor, including a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer.
(IV) Cholesterol screening for lipid disorders;
(V) (A) Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.
(B) In addition to covered persons eligible for colorectal cancer screening coverage in accordance with A or B recommendations of the task force, colorectal cancer screening coverage required by this subparagraph (V) shall also be provided to covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider;
(VI) Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP;
(VII) Influenza vaccinations pursuant to the schedule established by the ACIP;
(VIII) Pneumococcal vaccinations pursuant to the schedule established by the ACIP;
(IX) Tobacco use screening of adults and tobacco cessation interventions by primary care providers; and
(X) (A) Any other preventive services included in the A or B recommendation of the task force or required by federal law.
(B) This subparagraph (X) does not apply to grandfathered health benefit plans.
(c) For purposes of this subsection (18):
(I) "ACIP" means the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services, or any successor entity.
(II) "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit of the preventive health care service is substantial.
(III) "B recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
(IV) "Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.
(d) The health care service plan issued by an entity subject to part 4 of this article may provide that the benefits provided pursuant to this subsection (18) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.
(19) Hearing aids for children - legislative declaration. (a) The general assembly hereby finds and determines that the language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss. The general assembly therefore declares that providing hearing aids to children with hearing loss will reduce the costs borne by the state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.

(b) Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, must provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to article 29.9 of title 12, C.R.S. The hearing aids must be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage must include the purchase of the following:
(I) Initial hearing aids and replacement hearing aids not more frequently than every five years;
(II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
(III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
(c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured's policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.
(d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.
(20) Clinical trials and studies. (a) All individual and group health benefit plans shall provide coverage for routine patient care costs that a policy or certificate holder, or his or her dependent, receives during a clinical trial if:
(I) The covered person's treating physician, who is providing covered health care services to the person under the health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the covered person;
(II) The clinical trial or study is approved under the September 19, 2000, medicare national coverage decision regarding clinical trials, as amended;
(III) The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
(IV) Prior to participation in a clinical trial or study, the covered person has signed a statement of consent indicating that the covered person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the clinical trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the covered person's health benefit plan, and all out-of-network rates will apply; and
(V) The covered person suffers from a condition that is disabling, progressive, or life-threatening.
(b) The coverage required pursuant to paragraph (a) of this subsection (20) does not include:
(I) Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
(II) Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
(III) Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
(IV) An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
(V) Costs for the management of research relating to the clinical trial or study; or
(VI) Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the covered person's health plan.
(c) Nothing in this subsection (20) shall:
(I) Preclude a carrier from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device used in the clinical trial or study;
(II) Be interpreted to provide a private cause of action against a carrier for damages arising as a result of compliance with this section.
(d) For the purposes of this section:
(I) "Clinical trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.
(II) "Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the covered person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.
(21) Oral anticancer medication. (a) Any health benefit plan that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medication that has been approved by the federal

food and drug administration and is used to kill or slow the growth of cancerous cells. The orally administered medication shall be provided at a cost to the covered person not to exceed the coinsurance percentage or the copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided pursuant to this subsection (21) shall be prescribed only upon a finding that it is medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This subsection (21) does not require the use of orally administered medications as a replacement for other cancer medications. Nothing in this subsection (21) prohibits coverage for oral generic medications in a health benefit plan. Nothing in this subsection (21) prohibits a carrier from applying an appropriate formulary or other clinical management to any medication described in this subsection (21). For the purposes of this subsection (21), the treating physician for a patient covered under a health maintenance organization's health benefit plan shall be a physician who is designated by and affiliated with the health maintenance organization.

(b) A carrier shall not achieve compliance with this subsection (21) by imposing an increase in patient out-of-pocket costs with respect to anticancer medications used to kill or slow the growth of cancerous cells covered under a policy beyond the modifications permitted pursuant to section 10-16-105.1 (5).

(22) Prescription eye drop refill coverage. (a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides coverage for prescription eye drops shall provide coverage for:

(I) A renewal of prescription eye drops if:

(A) The renewal is requested by the insured at least twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops, from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; and

(B) The original prescription states that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed; and

(II) One additional bottle of prescription eye drops if:

(A) A bottle is requested by the insured or the health care provider at the time the original prescription is filled; and

(B) The original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three months.

(b) The prescription eye drop benefits covered under this subsection (22) are subject to the same annual deductibles, copayment, or coinsurance established for all other prescription drug benefits under the health benefit plan.

History

Source:

L. 92: Entire article R&RE, p. 1621, § 1, effective July 1; (4)(a) amended, p. 1499, § 32, effective July 1; (4) amended, p. 1752, § 7, effective July 1.L. 93: (5)(h) added, p. 956, § 2, effective May 28; (10) added, p. 2090, § 1, effective June 9.L. 94: (1.5), (6.5), (6.7) added and (6) amended, p. 1591, § 1, effective July 1; (5)(a), (5)(b)(I), (6), (8)(a), (8)(c), (8)(d), (9)(a)(I), (9)(b)(II), (9)(b)(III), and (9)(c) amended, pp. 2724, 2636, 2604, § § 321, 77, 2, effective July 1.L. 95: IP(4)(a), (4)(a)(II), (4)(a)(III), and (4)(b) amended, p. 486, § 1, effective May 16; (11) added, p. 590, § 1, effective May 22; (10) amended, p. 1389, § 1, effective June 5.L. 96: (1)(a) and (1)(b) amended, p. 123, § 1, effective August 7.L. 97: (7)(a)(I)(A) amended, p. 1131, § 3, effective May 28; (5.5) added, p. 193, § 1, effective January 1, 1998.L. 98: (1)(b) RC&RE and (3)(a) amended, pp. 52, 53, § § 1, 2, effective March 23; (5)(b)(II), (5)(b)(III), and (7)(a)(I)(B) amended, p. 1157, § 27, effective July 1; (13) added, p. 329, § 2, effective July 1; (12) added, p. 472, § 2, effective September 1; (6)(c) and (6)(d) amended, p. 1391, § 22, effective February 1, 1999.L. 99: (1)(c)(I) and (1)(c)(II)(A) amended and (1)(g) and (1.7) added, pp. 1045, 1046, § § 1, 2, effective January 1, 2000.L. 2000: (14) added, p. 1588, § 1, effective January 1, 2001.L. 2001: (5.5)(a)(I) amended, p. 984, § 1, effective August 8; (1)(c)(I) amended and (1)(c)(III) added, p. 931, § 1, effective January 1, 2002.L. 2003: (8)(a)(II) amended, p. 700, § 5, effective July 1; (15) added, p. 1774, § 9, effective July 1.L. 2004: (5)(c) amended, p. 981, § 4, effective August 4.L. 2006: (6.7)(a), (6.7)(b), and (8)(a)(I) amended, p. 1998, § 34, effective July 1; (15) amended, p. 1077, § 3, effective January 1, 2007.L. 2007: (17) added, p. 1348, § 3, effective May 29; (16) added, p. 378, § 1, effective August 3; (1.3) added and (1.7)(a)

amended, p. 889, § 3, effective January 1, 2008; (5.5)(a) amended and (5.5)(c) added, pp. 1369, 1370, § § 1, 2, effective January 1, 2008; (15) amended, p. 451, § 3, effective January 1, 2008.L. 2008: (1.3)(a) amended, p. 1467, § 12, effective August 5; (6)(a) amended, p. 386, § 2, effective August 5; (7)(a)(I)(B) and (7)(b)(II)(B) amended and (7)(c) added, p. 425, § 24, effective August 5; (19) added, p. 2005, § 1, effective January 1, 2009; (15) amended and (18) added, p. 2074, § 2, effective January 16, 2009.L. 2009: (1.3)(a)(VI), (1.3)(b), and (1.3)(e) amended and (1.3)(d.5) and (1.3)(f) added, (HB 09-1237), ch. 216, p. 977, § 1, effective May 2; IP(5), (5)(e), (5)(f), (5)(g), and (5.5)(b) amended, (HB 09-1338), ch. 353, p. 1844, § 4, effective July 1; (1.5), (6)(a), and (6.7)(a) amended, (SB 09-292), ch. 369, p. 1944, § 16, effective August 5; (20) added, (HB 09-1059), ch. 214, p. 969, § 1, effective August 5; (1.5), (4), (15), and (18) amended, (HB 09-1204), ch. 344, p. 1802, § 2, effective January 1, 2010; (1.3)(g) and (1.4) added, (SB 09-244), ch. 391, pp. 2113, 2114, § § 2, 3, effective July 1, 2010.L. 2010: (1.4)(a)(II)(A), (1.4)(a)(VIII), and (1.4)(a)(IX) amended, (HB 10-1260), ch. 403, p. 1978, § 50, effective July 1; (3)(a)(I) amended, (HB 10-1021), ch. 297, p. 1402, § 1, effective January 1, 2011; (18)(b)(III)(D) added, (HB 10-1252), ch. 226, p. 983, § 1, effective January 1, 2011; (21) added, (HB 10-1202), ch. 91, p. 310, § 2, effective January 1, 2011.L. 2011: IP(5) and (5)(b)(III) amended, (SB 11-187), ch. 285, p. 1326, § 65, effective July 1; (7)(a)(I)(A) amended, (HB 11-1186), ch. 97, p. 284, § 1, effective January 1, 2012.L. 2013: (5)(d)(I) repealed, (HB 13-1015), ch. 38, p. 109, § 2, effective March 15; (1.3)(b)(II), IP(1.3)(b)(IV), (1.3)(d.5), (1.4)(a)(IV), (1.4)(b), (5.5), IP(12)(a), IP(18)(a)(I), (18)(a)(III), IP(18)(b), (18)(b)(III), (18)(b)(VI), (18)(b)(VIII), (18)(b)(IX), and (21)(b) amended, (1.7)(c), (5), (7), (9), (11), (15), (16), and (18)(a)(II) repealed, and (18)(b)(X) added, (HB 13-1266), ch. 217, pp. 920, 978, § § 3, 28, 27, effective May 13; IP(19)(b) amended, (SB 13-039), ch. 288, p. 1536, § 4, effective May 24; (1.4)(a)(XI) amended, (SB 13-180), ch. 411, p. 2443, § 13, effective June 30; (1.4)(a)(VII) amended, (HB 13-1314), ch. 323, p. 1800, § 18, effective March 1, 2014.L. 2015: IP(1.4)(a)(II), (1.4)(a)(II)(E), (1.4)(a)(III), IP(1.4)(a)(XII), (1.4)(b)(I), and (5.5)(a)(IV)(B) amended and (1.4)(a)(II)(F) added, (SB 15-015), ch. 106, p. 308, § 2, effective January 1, 2017.L. 2016: (22) added, (HB 16-1095), ch. 12, p. 28, § 1, effective January 1, 2017; (1)(c)(III)(A) and (1)(c)(III)(C) amended, (HB 16-1387), ch. 203, p. 717, § 1, effective January 1, 2018.L. 2017: (5.5)(a)(I), (5.5)(a)(IV), and (18)(b)(I) amended, (SB17-242), ch. 263, p. 1264, § 35, effective May 25; (3)(a)(I) amended, (HB 17-1186), ch. 324, p. 1746, § 2, effective January 1, 2019.L. 2018: (1.3)(b)(II)(B) amended, (HB 18-1375), ch. 274, p. 1695, § 3, effective May 29; (6)(b) amended, (SB 18-095), ch. 96, p. 752, § 3, effective August 8; (5.5)(a)(III) amended, (HB 18-1007), ch. 225, p. 1431, § 1, effective January 1, 2019.

Annotations

Notes

Editor's note: (1) (a) The provisions of this section are similar to provisions of several former sections as they existed prior to 1992. For a detailed comparison, see the comparative tables located in the back of the index.

(b) Subsection (16) was relocated to § 10-16-105 (7) in 2013.

(2) Amendments to subsection (4)(a) by Senate Bill 92-012 were harmonized with amendments to subsection (4) by Senate Bill 92-179.

(3) Amendments to subsection (6) by Senate Bill 94-164 were harmonized with amendments by House Bill 94-1029.

(4) If the commission on mandated health insurance benefits twice fails to reach a quorum to consider the mandated health insurance coverage established by subsection (18) or concludes that the benefits of such mandated health

insurance coverage outweigh its harms, amendments to subsections (15) and (18) shall take effect. (See L. 2008, p. 2077.) On January 16, 2009, the revisor of statutes received notice from the division of insurance that the commission was unable to reach a quorum.

(5) Subsection (1.5) was amended in Senate Bill 09-292. Those amendments were superseded by the amendment to subsection (1.5) in House Bill 09-1204, effective January 1, 2010.

Cross references: (1) For limitations concerning medical or health insurance under the "Colorado Medical Treatment Decision Act", see § 15-18-111; for section 607 of the "Employee Retirement Income Security Act of 1974", see 29 U.S.C. § 1167.

(2) For the legislative declaration contained in the 1993 act adding subsection (5)(h), see section 1 of chapter 211, Session Laws of Colorado 1993. For the legislative declaration contained in the 1998 act adding subsection (12), see section 1 of chapter 162, Session Laws of Colorado 1998. For the legislative declaration contained in the 2006 act amending subsection (15), see section 1 of chapter 236, Session Laws of Colorado 2006. For the legislative declaration contained in the 2008 act amending subsection (15) and adding subsection (18), see section 1 of chapter 411, Session Laws of Colorado 2008. For the legislative declaration contained in the 2009 act adding subsections (1.3)(g) and (1.4), see section 1 of chapter 391, Session Laws of Colorado 2009. For the legislative declaration contained in the 2009 act amending subsections (1.5), (4), (15), and (18), see section 1 of chapter 344, Session Laws of Colorado 2009. For the legislative declaration contained in the 2010 act adding subsection (21), see section 1 of chapter 91, Session Laws of Colorado 2010. For the legislative declaration contained in the 2013 act repealing subsection (5)(d)(I), see section 1 of chapter 38, Session Laws of Colorado 2013. For the legislative declaration in SB 15-015, see section 1 of chapter 106, Session Laws of Colorado 2015. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-095, see section 1 of chapter 96, Session Laws of Colorado 2018.