Binder Filing Instructions for ACA Compliant Plans for Colorado Plan Year 2026

May 8, 2025

COLORADO
Department of Regulatory Agencies
Division of Insurance

CONNECT for HEALTH COLORADO™

Contents

INTRODUCTION

The purpose of these instructions is to provide comprehensive guidance on Binder filing procedures, to ensure that binder submissions are completed properly, efficiently, and in compliance with state and federal laws and regulations. The binder submission is one component of a complete health benefit plan filing for the 2026 plans. The additional components are:

1) Rate filing,
2) Form filing,
3) Mental Health Parity filing (QTL and Financial Requirements), and
4) Network Adequacy filing

For the 2026 plan year, the Colorado Division of Insurance (DOI) and Connect for Health Colorado (C4HCO) have jointly prepared filing instructions for rate, form, binder, and network adequacy submissions. Only one set of instructions will be provided for each filing type (rate, form, Summary of Benefits and Coverage (SBC) and the Colorado Supplement to the SBC (COSSBC), binder, and network adequacy), and may be accessed on the DOI website at ACA Annual Filings. The instructions and templates are under the blue heading ACA Annual Filing Types/Binders.

Any instructions or requirements that are specific to C4HCO will be clearly marked with the C4HCO logo.

All carriers submitting health benefit plans for the 2026 plan year must submit all five filings (rate, form, binder, mental health parity (medical only) and network adequacy) to the Division according to the timelines outlined below.

For the 2026 plan year, carriers offering individual and small group managed care plans with an effective date on or after January 1, 2026, for sale inside or outside of Connect for Health Colorado (C4HCO) are required to submit Network Adequacy Templates and supporting documentation for every network in the binder filing.

APPLICABILITY

These instructions are intended for all carriers, including health maintenance organizations, selling health benefit plans in Colorado that are required to comply with the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively known as the Affordable Care Act, and Colorado Insurance laws and regulations.

Filing Deadlines

Carriers offering individual and small group health benefit plans, on or off the exchange, with an effective date on or after January 1, 2026, are required to submit binder filings to the DOI no later than June 16, 2025.

Please follow this link to see the current plan year timeline: Current Plan Year Timeline.

All dates are dependent on CMS/CCIIO and SERFF and are subject to change.

BINDER FILING SUBMISSION REQUIREMENTS SUMMARY

All filings must be submitted through SERFF. For the 2026 plan year, the binder filing will be divided into four sections- Part 1, Part 2, and Part 4 - which will be due on different dates to streamline workflow and review processes. Part 3 is due to C4HCO on the date specified.

Binder Filing

PART 1 - DUE ON June 16, 2025

1) Templates Tab
    - Plans and Benefits Template (Federal)
    - Prescription Drug Template
    - Network ID Template
    - Service Area Template
    - Rating Business Rules Template
    - Transparency in Coverage template
2) Associate Schedule Items Tab
    - Form Schedule Items
    - Rate Schedule Items
3) Supporting Document Items
    - CO PBT (State) – with CO Add-In
    - 4-2-58 Formulary Compliance Template (State) REVISED
    - Prescription Drug Formulary Attestation Form (NEW)
    - URL template (State)
    - HIOS Plan ID Crosswalk Template (State) (REVISED)
    - Silver Plan ID Crosswalk (State)
    - Reinsurance Care Management Protocol Assessment (State)
    - Pharmacy Benefit Manager Template (State)
    - Confidentiality Index*
    - Justifications (as needed)
        - Discrimination – Cost Sharing Outlier*
        - Meaningful Difference Supporting Documentation and Justification*
        - Discrimination – Language*
        - Unique Plan Design*
        - EHB – Substituted Benefit (Actuarial Equivalent) *
        - Discrimination – Clinical Appropriateness*
        - Discrimination – Formulary Outlier*
        - Discrimination – Treatment Protocol*
        - Formulary – Inadequate Category/ Class Count*
        - Must include the carrier calculated Actuarial Value
        - Service Area Partial County Supplemental Response**

* If Applicable
** Required for carriers that offer stand-alone dental

PART 2 - DUE ON June 30, 2025

1) Templates Tab
   - Essential Community Providers/network Adequacy Template (ECP/NA)
   - Rate Data Template (With Reinsurance)
2) Supporting Documentation Tab
   - Network Adequacy Provider Listing (NEW)
   - 2026 Colorado Essential Community Providers Template (NEW)
   - 2026 Colorado Issuer ECP Attestation Template - Fillable
   - Colorado ECP Justification Template, if needed
   - Reinsurance Care Management Protocol Assessment (Appendix A)

Part 3 - DUE ON August 15, 2025

1) Supporting Documentation Tab
   - **Individual: - All variants**
     - All On-Exchange Plans
     - Evidence of Coverage (Dental and Medical) in English
     - Summary of Benefits and Coverage (SBC) in English
     - Colorado Supplement to the SBC in English

     - All (on- and off-exchange) Colorado Option Standardized Plans
     - Evidence of Coverage (Medical) in English
     - Summary of Benefits and Coverage (SBC) in English
     - Colorado Supplement to the SBC in English

     - All Colorado Connect (PBC) Plans (including -07 variant)
     - Evidence of Coverage (Medical) in English
     - Summary of Benefits and Coverage (SBC) in English
     - Colorado Supplement to the SBC in English
   - **Small Group:**
     - Only Colorado Option Standardized Plans
     - Evidence of Coverage in English
     - Summary of Benefits and Coverage (SBC) in English
     - Colorado Supplement to the SBC in English

PART 4 – DUE ON July 1, 2025

1) Connect for Health Colorado Required Documents
   - Marketing Plan Brochure(s) English and Spanish
   - Carrier Logo
   - Quality Overview Medical Only English and Spanish
   - Company Profile Dental English and Spanish
   - Dental SBC "Summary of Benefits & Coverage" English and Spanish
   - Provider Network

NEW ITEMS & REMINDERS FOR PLAN YEAR 2026 FILINGS

NEW FOR PY2026:

1. Character limit for Connect for Health Colorado's portal has been updated for consumer shopping transparency for Office Visits for Primary Care Provider, Specialty Provider, & Urgent Care visits. The limit is 30 characters or less. Suggested formatting is provided later in these instructions on page 13.
2. Per Colorado Insurance Bulletin 4.149, an additional EHB Benefit has been added to the Plan and Benefits Template (PBT) as Prosthetics: Recreational.
3. Colorado Insurance Regulation 4-2-58 contains new language for Copay Only Plan testing at 25% of total plans by metal level per service area must be copay only. For example, COS001 shall not account for COS002 and there is no overlapping of counts for the calculation methodology.

4. Tiering for Prescription Drugs has been defined in regulation more clearly and prescribes that Tier 1 is Preventive Drugs and Tier 2 is the lowest cost tier. This aligns with the Colorado Option Standardized plans in Colorado Insurance Regulation 4-2-81.

REMINDERS:

1. Please ensure **Bronze Colorado Option** plans are on **Benefit Package 2** of the federal and CO-specific PBTs.
2. Further guidance is provided in these instructions on page 8 under sub-section "C*ompleting the Cost Sharing Fields on the Federal and CO PBTs*" to know when to use "No Charge", "$0", and "Not Applicable" when completing the Colorado Option plans on both Plans and Benefits templates. Additionally, the combined Deductible and Maximum Out-of-Pockets amounts for Colorado Option plans.
3. Each health benefit plan must have its own Health Insurance Oversight System (HIOS) plan ID. If a new plan is created, a previously used HIOS plan ID may NOT be re-used – a unique HIOS plan ID must be created for the new plan. Please refer to CMS for further guidance.
4. For diabetic supply coverage: Per Colorado Insurance Regulation 4-2-81 requires coverage for diabetes supplies, including Continuous Glucose Monitors. This must be provided with no-cost sharing and must be reflected in all consumer-facing documents.
5. Carriers shall list all "On the Exchange" plans as "Both", pursuant to § 10-16-105 C.R.S.
   - The Division will be evaluating carrier submissions and will be objecting to any plan listed as "On the Exchange."
6. Issuer AV versus AVC: Carriers shall enter the Issuer AV on all Standardized Plans, utilizing the AV values found in Colorado Insurance Regulation 4-2-81. ***Do not round up to the tenth or full percentage place.***
7. *Zip files and the consumer-facing documents:*
   - Please continue to utilize zip files for SBCs Please upload under the appropriate user-added heading for the English and Spanish translated plan level SBCs/EOCs/COSSBCs.

TEMPLATES TAB

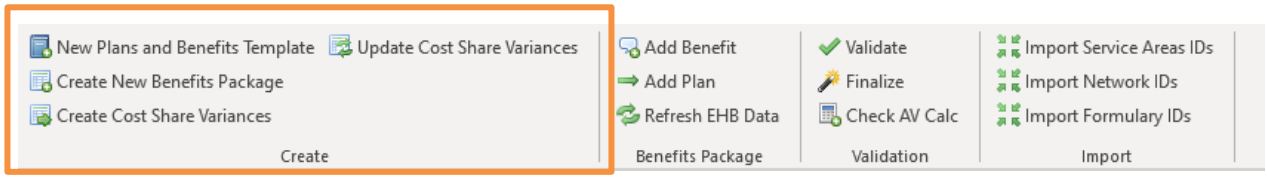
The final 2026 Plan Filing –Templates and general instructions can be found on the CMS/CCIIO website (https://www.qhpcertification.cms.gov/s/Application%20Materials), along with the latest add-in file versions of the state-specific benchmark data and AV calculator. When visiting the CCIIO site, please validate that only working 2026 templates and instructions are being used.

COLORADO OPTION STANDARDIZED PLANS REQUIREMENTS

For the 2026 plan year, carriers shall submit two PBTs: the federal PBT and the Colorado PBT.

The Colorado PBT will contain both the off-exchange (00) variant, as well as the -07 variant for the Colorado Option Plans for the Public Benefit Corporation (PBC) and displayed on Colorado Connect.

The Division has developed a Colorado specific add-in that carriers must use for the Colorado Option Silver Enhanced Plan (-07 variant) to be offered on Colorado Connect (i.e., Public Benefit Corporation). Much like the normal PBT, carriers will select the "Create Cost Share Variances" button, and this will automatically load the -07 variant.



Carriers will then see the -07 variant populated under the Silver plan.

HIOS Plan ID (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage (Metal Level)	CSR Variation Type	Issuer Actuarial Value
12345CO1234568-00	Example Carrier Colorado Option Standardized Silver	Silver	Standard Silver Off Exchange Plan	
12345CO1234568-07	Example Carrier Colorado Option Standardized Silver	Silver Enhanced	Standard Silver Enhanced Off Exchange Plan	

Completing the Actuarial Value (AV) on the Federal and CO PBTs

The Wakely plan design certification represents the cost-sharing components that are prescribed in the standardized plan designs. Carriers should enter the Colorado Option plans as unique plan designs, and enter the actuarial value from the certification as the Issuer Actuarial Value. However, if there are other cost-sharing components that are not prescribed in the standardized plan designs, carriers should offer the same cost-sharing for these services as to what is offered for closely related benefits defined in the standardized plan designs. If a carrier anticipates that their actuarial value will be outside of +/- 0.1% compared to Wakely's certified actuarial value, due to any benefits outside of those defined in the standardized plan designs, the carrier is responsible for providing an additional certification explaining the impacts. The carrier is also responsible for ensuring that any non-prescribed benefits would not impact the plan meeting the Federal actuarial de minimis requirements. The target rates will not be adjusted for any differences in actuarial values compared to those used in the target rate methodology (based on the prescribed standardized benefits).

Completing the Cost Sharing Fields on the Federal and CO PBTs

For Colorado Option plans on both the federal and state Plans and Benefits templates, the federal QHP rules continue to apply when to use "No Charge" and "Not Applicable." If there is cost sharing in the coinsurance field and no copay, the Copay field should be "Not Applicable." If there is "No Charge" in the copay field, and no coinsurance, then "Not Applicable" should be in the coinsurance field. If there is a coinsurance and no copay, then "Not Applicable" should be in the copay field.

Note: The Copay and Coinsurance fields cannot both be "Not Applicable." This is per the QHP

Application Instructions.

Please see below for examples.

Benefit	Copay	Coinsurance
W: No copay, 25% coinsurance after deductible	Not Applicable	25% coinsurance after deductible
X: Zero dollar copay, no deductible applied and no coinsurance	No Charge	Not Applicable
Y: $25 copay no coinsurance, no deductible applied	$25	Not Applicable
Z: $55 copay and 10% coinsurance after deductible	$55 with deductible	10% coinsurance after deductible

Combined Deductible and Maximum Out-of-Pocket Amounts

For Colorado Option Plans ONLY please place the plan's Deductible amount in the "Combined Medical and Drug EHB Deductible" field per Colorado Insurance Regulation 4-2-81. Similarly, for the Maximum Out-of-Pocket amount, please use the "Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)" field.

PLANS AND BENEFITS TEMPLATE

The Plans and Benefits Template (PBT) must be submitted on the Template Tab in the binder filing, and contains two sections (tabs):

1) "Benefits Package" tab, which includes high-level information regarding the plans, as well as a list of benefits with any quantitative limits or exclusions. All plans defined within a Benefits Package will share the same set of benefits and limits but may differ in cost sharing; and

2) "Cost Share Variances" tab, created for each "Benefits Package", allows carriers to provide cost share information for each benefit identified as covered. Carriers must input all cost sharing information, as indicated below and in the Federal instructions for the "Cost Share Variances."

For general assistance in filling out the templates, please refer to the federal instructions available at: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.

NOTE: The PBT instructions contained in this document marked with the C4HCO logo are requirements that affect system logic and/or plan display on the C4HCO website.

PLANS AND BENEFITS TEMPLATE: MEDICAL CARRIERS

To provide the most consistent review and a consistent display of plan benefit data on the C4HCO website, the Division and C4HCO require all carriers to list the benefits as shown in this section.

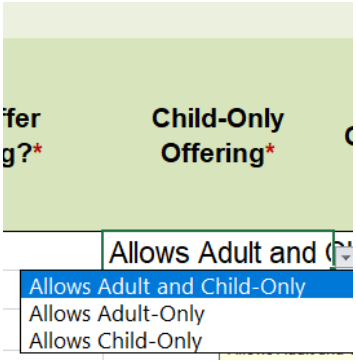
Consistent data allows for more timely reviews and ensures that C4HCO receives the appropriate information. To see the QHP benefit order and scope for the C4HCO detail benefit page during the 2026 open enrollment period, please refer to APPENDIX B: C4HCO MEDICAL DETAIL BENEFIT PAGE DISPLAY ORDER.

BENEFIT PACKAGE TAB INSTRUCTIONS: MEDICAL CARRIERS

This section applies to the "Benefit Package" tab within the PBT. To complete this tab, please validate the 2026 PBT is being used. Be sure to open the corresponding PBT add-in file prior to beginning. This will load the state specific benefits.

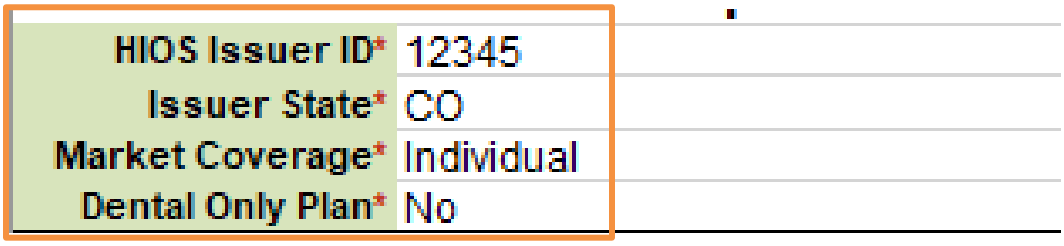
PLAN ATTRIBUTES: CHILD AND ADULT ONLY PLANS

All **individual market QHPs** on C4HCO must allow adult-only enrollment, child-only enrollment, or both child and adult enrollment together. To indicate this in the "Plan Attributes" section, please select the "Allows Adult and Child-Only" dropdown option when completing the "Child-Only Offering" question shown below.



BBENEFIT INFORMATION AND GENERAL INFORMATION

Prior to completing the "Benefit Information" and "General Information" sections on this tab, carriers must refresh the EHB data to reflect Colorado specific EHBs. To identify which benefits are EHB, non-EHB, or state mandated, first populate "Issuer State" and 'Market Coverage" then hit the "Refresh EHB Data" button.



The pre-loaded EHB benefits will populate with a “Yes” and non-EHB benefits will be blank.

Benefit Information		
Benefits	**EHB**	**Is this Benefit Covered?**
Primary Care Visit to Treat an Injury or Illness	Yes	Covered
Specialist Visit	Yes	Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered
Outpatient Surgery Physician/Surgical Services	Yes	Covered
Hospice Services	Yes	Covered
Routine Dental Services (Adult)		

When completing the remaining details in this benefit section, the following actions must be taken:

EHB Benefits: Carriers must cover and populate applicable limit and exclusion details for all benefits where EHB = Yes. Most of these benefits will be used for display on the C4HCO website.

1) We will be utilizing the Rehabilitative Occupational Therapy, Rehabilitative Physical Therapy, Rehabilitative Speech Therapy and Habilitative therapy, as designated on the Plans & Benefits template and below. **Please enter Carrier specific limits for the following EHB benefits:**
    a. Rehabilitative Speech Therapy
    b. Rehabilitative Occupational Therapy
        i. For the combined Rehabilitative Occupational Therapy/Physical Therapy benefit and Outpatient Rehabilitation Services, please mark this as covered and provide the combined maximums, as well as the cost sharing. This field is used as part of the Non-Discrimination tools.
    c. Rehabilitative Physical Therapy
        i. For the combined Rehabilitative Occupational Therapy/Physical Therapy benefit and Outpatient Rehabilitation Services, please mark this as covered and provide the combined maximums, as well as the cost sharing. This field is used as part of the Non-Discrimination tools.
        ii. Carriers are not required to enter any language in the benefit explanation field.
    d. Habilitative Benefits
        i. Enter 60 visits in the Quantitative Limits, if this is the combined limit
        ii. In the Benefit Explanation field, please place the following language (required):

1. 20 visits for Physical Therapy/ 20 visits for Occupational Therapy/ 20 visits for Speech Therapy

NOTE: IF carriers cover more than 20 visits for any of the therapies, please update the total number of visits in the quantitative limits to the appropriate number of visits (e.g. 90 visits) and the therapies to show the correct maximum (e.g. 30 visits for Speech Therapy/ 30 visits for Occupational Therapy/ 30 visits for Physical Therapy).

USE IF COVERING MINIMUM VISITS

Benefit Information					General Information			Out of Pocket Exceptions	
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason	Excluded from In Network MOOP	Excluded from Out of Network MOOP
Habilitation Services	Yes	Covered	Yes	60	Visit(s) per Year		20 visits for Physical Therapy/ 20 visits for Occupational Therapy/ 20 visits for Speech Therapy		No	No

USE IF COVERING MORE THAN MINIMUM VISITS

Benefit Information					General Information			Out of Pocket Exceptions	
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason	Excluded from In Network MOOP	Excluded from Out of Network MOOP
Habilitation Services	Yes	Covered	Yes	90	Visit(s) per Year		30 visits for Physical Therapy/ 30 visits for Occupational Therapy/ 30 visits for Speech Therapy		No	No

IMPORTANT NOTE: Please delete the pre-populated data from the Exclusions and Benefit Explanation fields. The Division and Connect for Health Colorado will not be utilizing any of the pre-populated language.

<u>Colorado Option Bronze</u> plans should be listed on <u>Benefit Package Tab 2</u> include the following language in the Benefit Explanation field:

"First 3 visits at $0"

IMPORTANT NOTE: To assist with the shopping experience, C4HCO will be able to load the information that populates in the benefit explanation fields, on a limited basis. Except for the language noted above for habilitation services (required).

The fields should only contain information that will explain additional benefit information (Benefit Explanation Field) or limitations that are not presented elsewhere in the template.

Please use these fields only when required to enhance the shopping experience. The Benefit Explanation fields will be reviewed by both the Division and C4HCO to ensure that they are of appropriate length and will enhance the shopping experience.

Benefit Information		*General Information*					
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation
Primary Care Visit to Treat an Injury or Illness	Yes	Covered					
Specialist Visit	Yes	Covered					
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered					
Outpatient Surgery Physician/Surgical Services	Yes	Covered					
Hospice Services	Yes	Covered					If a Plan Physician
Routine Dental Services (Adult)							
Infertility Treatment	Yes	Covered					We cover the following
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing	Yes	Covered					For hospital inpatient care,

For a full list of QHP, benefits that will be displayed on the C4HCO website, please refer to APPENDIX B: C4HCO MEDICAL DETAIL BENEFIT PAGE DISPLAY ORDER.

NEW for PY26:

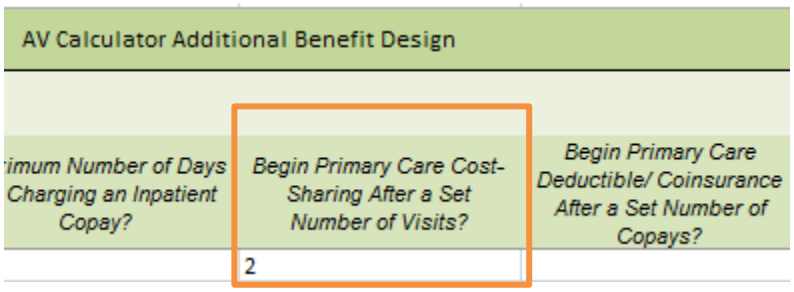
Benefit Explanation fields for **Primary Care, Specialty, and Urgent Care Office Visits** on the Benefits Package, subject to a **30-character max**.

Suggested formats are below:

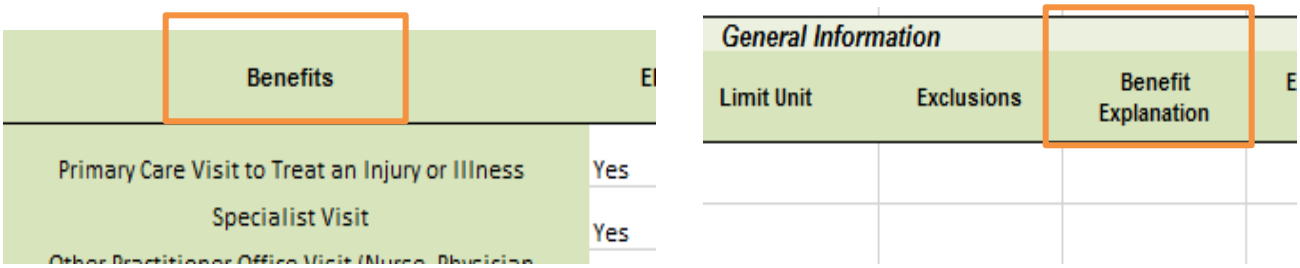
First Visit, Then Cost Sharing	First Two (2) Visits, Then Cost Sharing	First Three (3) Visits, Then Cost Sharing
First visit $50 - ded/coin First visit $150 - ded/coin	First 2 visits $60 - ded/coin First 2 visits $150 - ded/coin First 2 visits $50 - ded/coin	First 3 visits $0 - ded/$50 First 3 visits $45 - ded/coin First 3 visits $55 - ded/coin First 3 visits $50 - ded/coin Frist 3 visits $150 - ded/coin First 3 visits $0 - ded/coin

Please note: These are examples and will be tested upon receipt in the binder within the Plans and Benefits Template.

The Cost Share Variance Tab in the AV Calculator Additional Benefit Design will show the quantity of visits.



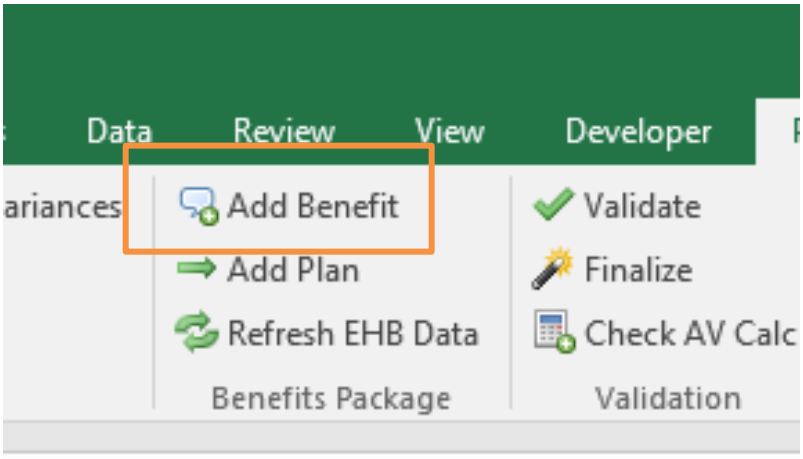
Benefits Package tab Benefit Explanation cell



HOW TO ADD CUSTOM BENEFITS

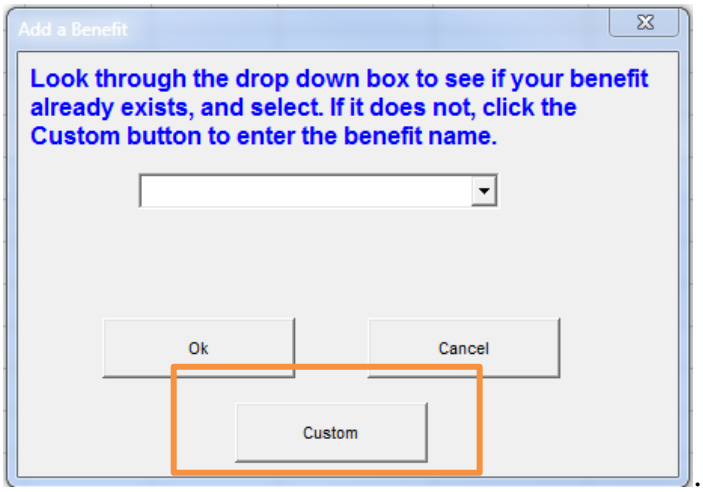
ADD CUSTOM BENEFIT: STEP 1

At the top of the Plans and Benefits Template, carriers will find and hit the "Add Benefit" button.



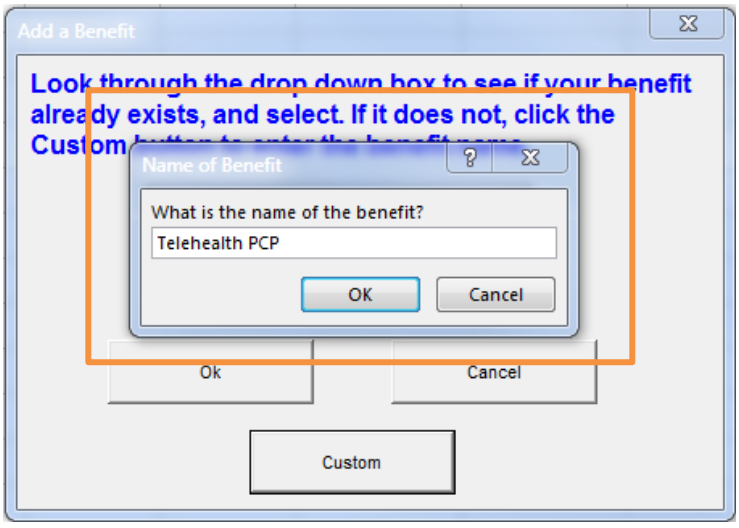
ADD CUSTOM BENEFIT: STEP 2

Carriers should now see the following pop-up box. Hit the "Custom" button.



ADD CUSTOM BENEFIT: STEP 3

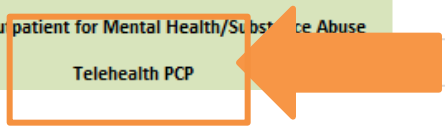
Carriers should now see the following pop-up box. Enter the name of the benefit using the **copy and paste function**, from the Custom Benefits list below. Hit "OK".



ADD CUSTOM BENEFIT: STEP 4

The added benefit should now appear at the bottom of the list of benefits on the left-hand side of the template. Confirm that it has populated correctly.

Applied Behavior Analysis Based Therapies		Covered			
Autism Spectrum Disorders		Covered			
Partial Hospitalization for Mental Health/Substance Abuse		Covered			
Residential Day Treatment for Mental Health/Substance Abuse		Covered			
Intensive Outpatient for Mental Health/Substance Abuse		Covered			
Telehealth PCP		Covered			



CUSTOM EHB BENEFITS: REQUIRED ADDITIONS FOR ON EXCHANGE AND OFF EXCHANGE QHPS

The Division is requiring the addition of all the below benefits for compliance reasons. **Carriers must enter the benefits indicated below exactly as shown. They do not need to be entered in the order listed below.** All benefits listed below are required to be covered, as they are included in the Essential Health Benefits package in §10-16-102(22) C.R.S., Colorado Insurance Regulation 4-2-42 and the Colorado Benchmark plan.

Mental Health Parity (MHP) will continue to have a substantial amount of attention in the review process. The Plans & Benefits Template already has Mental/Behavioral Health Services and Substance Use Disorder for both inpatient and outpatient services. As has been the case for the last several years, the Division is requiring all additional EHBs to be separated by Mental/Behavioral Health Services and Substance Use Disorder. Each should have their own cost sharing by plan, as any other stand-alone benefit.

Prescription Drugs: Each plan's cost sharing is subject to Colorado Insurance Regulation 4-2-58.

When filling out the additional EHB **Autism Spectrum Disorders-Assessment and Evaluation**, please use the benefit associated with assessment and evaluation services, as §10-16-104(1.4)(a)(XII) C.R.S. requires coverage for seven (7) different benefits. The remaining six (6) benefits are covered under the plan, as Colorado law requires parity between autism and all other covered benefits.

Carriers are required to cover **Telehealth**, in accordance with § 10-16-123 C.R.S., with cost sharing that shall not exceed the cost sharing required under the same type of service, as if the person were seen by the provider in-person. The Division will be utilizing the cost sharing reported as part of the Binder filing to ensure that the telehealth benefits comply with the requirements of §10-16-123 C.R.S.

Prosthetics: Legs and Arms are regulated under §10-16-104(14) C.R.S. This requires carriers to reimburse arm and leg prosthetics at 80%, after the Medicare Part B deductible for the particular benefit year, as clarified in Colorado Insurance Bulletin B-4.97. The specific language entered on the PBT should not include "with deductible" or "after deductible" as this will flag as non-compliant to the statutory requirements. Catastrophic plans and health savings account eligible plans are exempt from this requirement, as required under federal law.

Plan Year 2026 REMINDER: When completing the Plans and Benefits templates, please use the Medicare Part B Deductible as the COPAY for this benefit and then enter "20%" as the coinsurance.

NOTE: Do not enter ANY deductible language such as "with deductible" or "after deductible."

The copay and coinsurance may be less than or equal to the Medicare Part B Deductible and Copay amounts but not more than.

Carriers are required to include all benefits from the table below and if any benefits are missing, the carrier will be required to add the benefit to the Plans and Benefits Template.

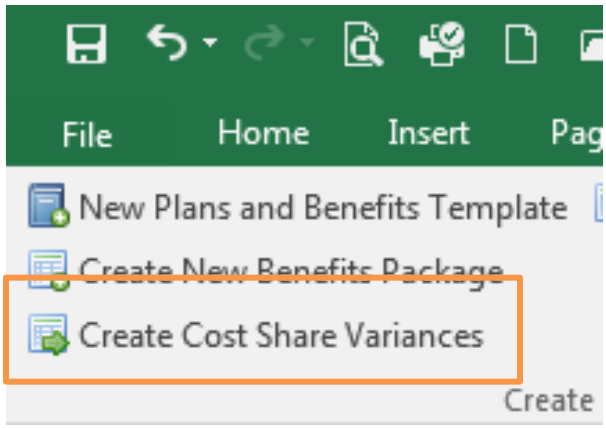
IMPORTANT NOTE: Please copy and paste the benefit names directly from this list. Typing the values into the template will increase the likelihood for errors. Any inconsistencies between the benefit names listed below and the input will cause the benefit to receive an objection and for some benefits, they will not appear on the C4HCO website.

Custom EHB Benefits	EHB Variance Reason
Partial Hospitalization for Mental/Behavioral Health	Additional EHB Benefit
Partial Hospitalization for Substance Use Disorder	Additional EHB Benefit
Residential Day Treatment for Mental/Behavioral Health	Additional EHB Benefit
Residential Day Treatment for Substance Use Disorder	Additional EHB Benefit
Intensive Outpatient for Mental/Behavioral Health	Additional EHB Benefit
Intensive Outpatient for Substance Use Disorder	Additional EHB Benefit
Inpatient Rehabilitation	Additional EHB Benefit
Rehabilitative Physical Therapy	Additional EHB Benefit
Rehabilitative Occupational Therapy	Additional EHB Benefit
Prosthetics: Legs and Arms	Additional EHB Benefit
Applied Behavior Analysis Based Therapies	Additional EHB Benefit
Autism Spectrum Disorders – Assessment and Evaluation Services	Additional EHB Benefit
Mental/Behavioral Health Prenatal Care	Additional EHB Benefit
Mental Health Wellness Visit	Additional EHB Benefit
Substance Use Disorder Prenatal Care	Additional EHB Benefit
Postpartum Mental/Behavioral Health	Additional EHB Benefit
Postpartum Substance Use Disorder	Additional EHB Benefit
Telehealth Mental/Behavioral Health	Additional EHB Benefit
Telehealth Substance Use Disorder	Additional EHB Benefit
Telehealth PCP	Additional EHB Benefit

Telehealth Specialist	Additional EHB Benefit
Office Visit – Mental/Behavioral Health	Additional EHB Benefit
Office Visit – Substance Use Disorder	Additional EHB Benefit
Diabetic Supplies	Additional EHB Benefit
Preventive Drugs	Additional EHB Benefit
Non-Preferred Generic Drugs	Additional EHB Benefit
Medical Service Drugs	Additional EHB Benefit
Prosthetics: Recreational	Additional EHB Benefit
Standalone Laboratory	Additional EHB Benefit

COST SHARE VARIANCE TAB INSTRUCTIONS: MEDICAL CARRIERS

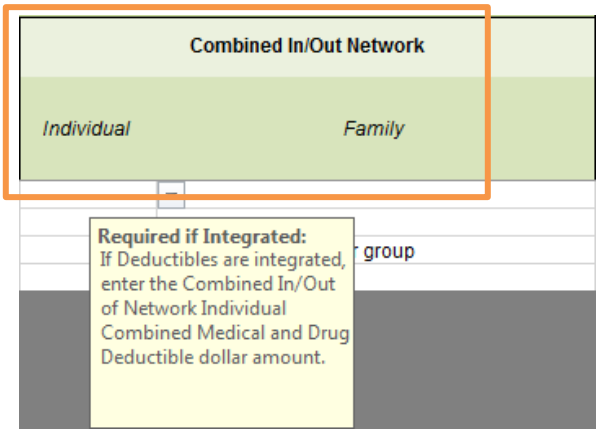
Once carriers have completed the required sections on the "Benefits Package" tab, it is ready to create a Cost Share Variance Tab. Hit the "Create Cost Share Variances" option.



HEALTH SAVINGS ACCOUNTS / HIGH DEDUCTIBLE HEALTH PLANS

For all HSA plans and any other plans that integrate the medical and drug deductible, please use the "Combined Medical and Drug EHB Deductible" section when populating the deductible amounts.

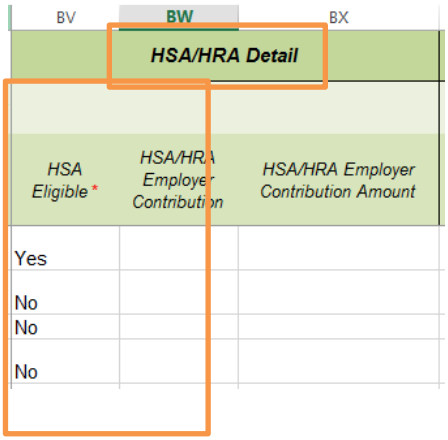
NOTE: Please make necessary updates to these amounts based on the release of the final 2026 parameters for HSA eligibility.



HSA ELIGIBILITY

Eligible High Deductible Health Plans (HDHP) HSA plans require a minimum deductible and maximum out-of-pocket based on federal requirements.

For HSA eligible plans please mark “Yes” in the box “HSA Eligible”. Please check all plan variants for compliance with the IRS Rules for HSA eligibility, as some plan variants may fall below the IRS minimum amounts for the deductible.



HSA PLAN DEDUCTIBLE AND OUT-OF-POCKET

In the 2017 Notice of Benefit and Payment Parameters, CMS and the IRS clarified a provision on plans that are HSA eligible. The IRS has not released the 2026 HSA minimum deductible and maximum out of pocket as of the publishing of these instructions. All scenarios that follow are for illustrative purposes only.

What does this mean?

Here are some scenarios that would require adjustment to the individual out-of-pocket maximum for plans with an aggregate deductible or out-of-pocket maximum to limit the individual out-of-pocket maximum to $8,050.

SCENARIO 1

Individual Deductible: $1,500
Family Aggregate Deductible: $3,000
Family Aggregate Out-of-Pocket Maximum: $6,000
This plan would not exceed the Notice maximum of $8,050.

Deductible

	In Network	
	Individual	*Family*
	$1,500	per person not applicable | $3000 per group

Out-of-Pocket

	In Network	
	Individual	*Family*
	$3,000	per person not applicable | $6000 per group

SCENARIO 2

Individual Deductible: $2,700
Family Aggregate Deductible: $5,400
Individual Out-of-pocket: $7,000
Aggregate Out-of-Pocket Maximum: $14,000.

Deductible

	In Network	
	Individual	*Family*
$2,700	per person not applicable | $5400 per group	

Out-of-Pocket

	In Network	
	Individual	*Family*
$7,000	$9100 per person | $14000 per group	

The individual out-of-pocket maximum would have to be added to this plan, but claims do not have to be paid prior to the deductible being met.

SCENARIO 3

Individual Deductible: $5,000
Family Aggregate deductible: $10,000
Individual Out-of-Pocket: $6,650
Family Aggregate Out-of-Pocket Maximum: $13,300

Deductible

	In Network	
Individual	*Family*	
$5,000	$9100 per person | $10000 per group	

Out-of-Pocket

	In Network	
Individual	*Family*	
$6,650	$9100 per person | $13300 per group	

COPAYMENT AND COINSURANCE LEVELS

Copayment and coinsurance information displayed on the C4HCO website comes directly from the values entered on the "Cost Share Variance" tab. If the copayment or coinsurance applies after the deductible or with the deductible, please use the appropriate dropdown option to indicate this nuance. The preferred dropdown options are $X Copayment with deductible OR X% Coinsurance after deductible. Please avoid using $X or X% when possible. This has caused customer confusion and may lead to a misinterpretation of the benefits.

USE IF DEDUCTIBLE DOES NOT APPLY

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
Not Applicable		Not Applicable	25.00%		100.00%
$0.00		$0.00	0.00%		0.00%
Not Applicable		Not Applicable	25.00%		100.00%
Not Applicable		Not Applicable	20.00%		

USE IF DEDUCTIBLE APPLIES

Primary Care Visit to Treat an Injury or Illness			
Copay		Coinsurance	
In Network (Tier 1)		*In Network (Tier 1)*	*In Network (Tier 2)*
$25.00 Copay after deductible		40.00% Coinsurance after deductible	
$25.00 Copay after deductible		40.00% Coinsurance after deductible	
	$0.00	0.00%	0.00%
$25.00 Copay after deductible		40.00% Coinsurance after deductible	

If the deductible applies, please ensure that the order of copay/deductible/coinsurance follows the plan design.

USE IF DEDUCTIBLE APPLIES AFTER FIRST 3 VISITS (Note the Copay in the Benefit Explanation Field)

Calculator Additional Benefit Design		Primary Care Visit to Treat an Injury or Illness				
		Copay			Coinsurance	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	*Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
3		$25.00 Copay after deductible		Not Applicable	Not Applicable	
		$0.00		$0.00	0.00%	
3		$25.00 Copay after deductible		Not Applicable	Not Applicable	

Continued…

' Calculator Additional Benefit Design		Primary Care Visit to Treat an Injury or Illness				
		Copay			Coinsurance	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)
3		Not Applicable		Not Applicable	20.00% Coinsurance after deductible	
		$0.00		$0.00	0.00%	
3		Not Applicable		Not Applicable	20.00% Coinsurance after deductible	

NOTE: Carriers must enter the following language in the Benefit Explanation field on the Benefit Package tab: "Copay applies for first [x] visits, then ded/coins"

Non-Covered Benefits

C4HCO's plan display is dependent on the data provided by the team in the templates. The template's dropdown values for copay and coinsurance are restrictive and not particularly customer friendly. For 2026, the Division and C4HCO will be using the Federal guidelines for non-covered benefits.

CORRECT / PREFERRED

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
$20		Not Applicable	Not Applicable		100%
$20		Not Applicable	Not Applicable		100%
$0		$0	0%		0%
$20		Not Applicable	Not Applicable		100%

INCORRECT / NOT PREFFERED

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
Not Applicable		$0	50% Coinsurance after deductible		100%
Not Applicable		$0	50% Coinsurance after deductible		100%
$0		$0	0%		0%
Not Applicable		$0	50% Coinsurance after deductible		100%

Preventive Care

When populating the copay and coinsurance for the "Preventive Care / Screening / Immunization" benefit, please select "No Charge" instead of listing "$0" or "100%" as shown below.

CORRECT / PREFFERED (Preventive Care Out-of-Network Not Covered)

Preventive Care/Screening/Immunization					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		Not Applicable	No Charge		100.00%

INCORRECT / NOT PREFFERED (Preventive Care Out-of-Network Not Covered)

Preventive Care/Screening/Immunization					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$0.00		Not Applicable	No Charge		100.00%

PLANS AND BENEFITS TEMPLATE: DENTAL CARRIERS

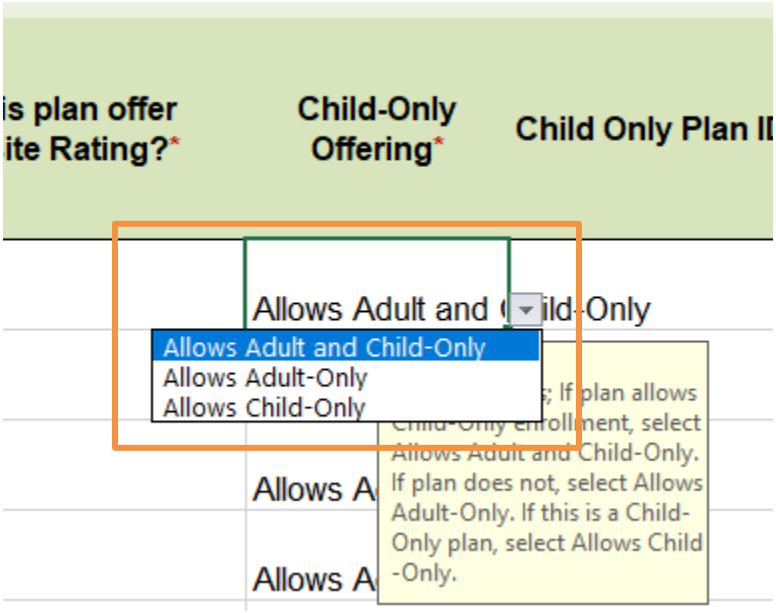
To provide the most consistent review and a consistent display of plan benefit data on the C4HCO website, the Division and C4HCO require all carriers to list the benefits as shown in this section. Consistent data allows for more timely reviews and ensures that C4HCO receives the appropriate information. To see the QHP benefit order and scope for the C4HCO detail benefit page during the 2026 open enrollment period, please refer to APPENDIX B: C4HCO MEDICAL DETAIL BENEFIT PAGE DISPLAY ORDER.

BENEFIT PACKAGE TAB INSTRUCTIONS: DENTAL CARRIERS

This section applies to the "Benefit Package" tab within the PBT. To complete this tab, please validate the 2026 SERFF benefit template is being used. Be sure to open the corresponding PBT add-in file prior to beginning. This will allow the template's macros to activate. For additional instructions and support in populating this template, please utilize the FFM instructions here: https://www.qhpcertification.cms.gov/s/QHP.

PLAN ATTRIBUTES: CHILD AND ADULT ONLY PLANS

All **individual market QDPs** on C4HCO must allow adult only enrollment, child only enrollment, or both child and adult enrollment together. To indicate this in the "Plan Attributes" section, please select the "Allows Adult and Child-Only" dropdown option when completing the "Child Only Offering" question shown below.



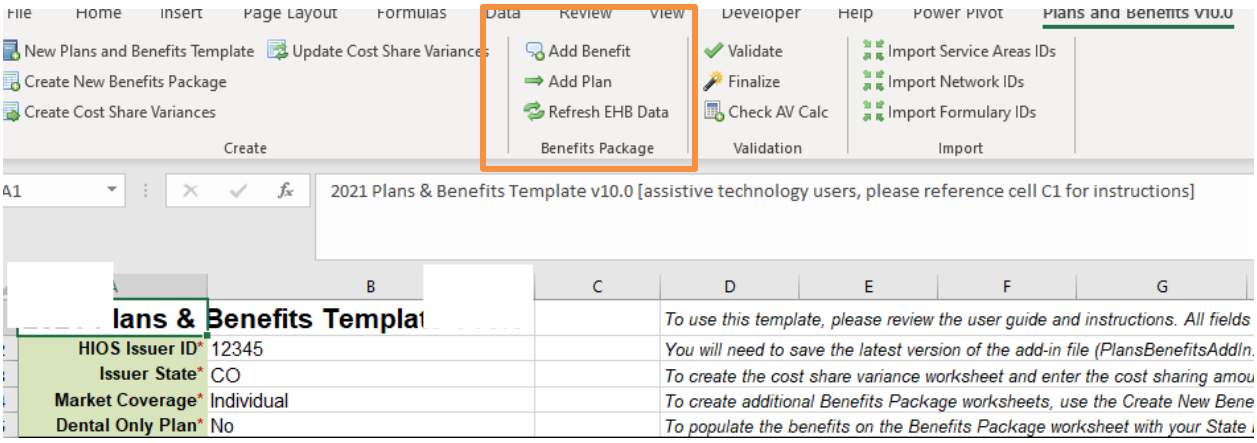
PLAN ATTRIBUTES: STAND ALONE DENTAL ONLY

All **individual market QDPs** must provide the percentage associated to the pediatric dental EHBs. To indicate this in the "Plan Attributes" section, populate the "EHB Apportionment for Pediatric Dental" shown below. In addition, all **SHOP and individual market QDPs** must offer guaranteed rates through C4HCO. This means carriers must select "Guaranteed Rate" as shown below.

For Connect for Health Colorado to display the correct information, the dollar amount will be requested later for the EHB apportionment.

BENEFIT INFORMATION AND GENERAL INFORMATION

Prior to completing the "Benefit Information" and "General Information" sections on this tab, Carriers must refresh the EHB data to reflect Colorado specific EHBs. To identify which benefits are EHB, non-EHB, or state mandated, first populate "Issuer State", "Market Coverage", "Dental Only Plan", and then hit the "Refresh EHB Data" button.



The pre-loaded EHB benefits will populate with a "Yes" and non-EHB benefits will be blank.

Benefit Information					General Info
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit
Routine Dental Services (Adult)		Not Covered			
Dental Check-Up for Children	Yes	Covered			
Basic Dental Care – Child	Yes	Not Covered			
Orthodontia – Child	Yes	Not Covered			
Major Dental Care – Child	Yes	Not Covered			
Basic Dental Care – Adult		Not Covered			
Orthodontia – Adult		Not Covered			
Major Dental Care – Adult		Not Covered			
Accidental Dental		Not Covered			

CUSTOM EHB/NON-EHB BENEFITS: REQUIRED ADDITIONS FOR ON EXCHANGE AND OFF EXCHANGE QDPS

No carriers should use the benefits pre-populated by CMS. Also, p**lease <u>do NOT enter carrier specific limits and exclusions</u>** on any of the benefits populated by CMS.

All dental carriers must enter the benefits listed below as custom benefits. The Division uses these benefits to confirm that carriers are covering all the required benefits for pediatric dental. The Division does not use the benefits pre-populated in the template by CMS.

IMPORTANT NOTE FOR ON EXCHANGE CARRIERS: To assist with the shopping experience, C4HCO will be able to load the information that is populated in the exclusions and benefit explanation fields, on a limited basis. **<u>We are limiting these fields to 50 characters</u>. The fields should only contain information that will explain additional benefit information (Benefit Explanation Field) that are not presented elsewhere in the template.** Please use these fields only when required to enhance the shopping experience. Both the Division and C4HCO will review these fields to ensure that they are of appropriate length and that they will enhance the shopping experience.

Benefit Information		General Information						
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
Primary Care Visit to Treat an Injury or Illness	Yes	Covered						
Specialist Visit	Yes	Covered						
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered						
Outpatient Surgery Physician/Surgical Services	Yes	Covered						
Hospice Services	Yes	Covered					If a Plan Physician	

The Division and C4HCO requires all dental carriers in both the SHOP and Individual markets to add the custom benefits in the table below to the PBT. The carriers are required to cover most, if not all, child benefits. Adult benefits are not required to be covered. However, carriers are required to enter whether or not they cover the benefits so they can be added to the plan detail page for display. This

will allow C4HCO to map the custom benefits consistently among the carriers.

Please create the new custom benefits in the order listed below. Only the benefits as they are listed will be displayed to consumers.

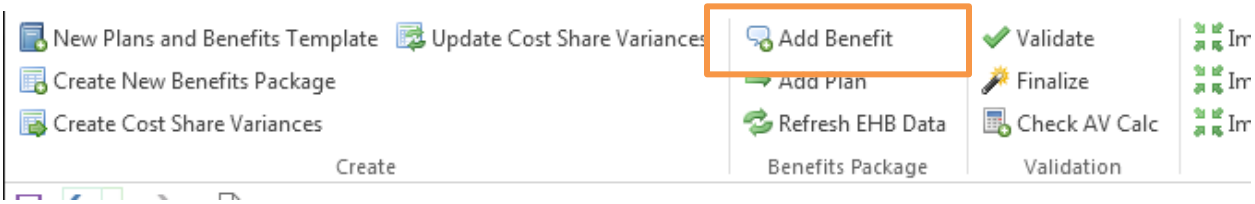
IMPORTANT NOTE: Please copy and paste the benefit names directly from this list. Typing the values into the template will increase the likelihood for errors. Any inconsistencies between the C4HCO benefit names listed below and carrier input will cause the benefit to not appear on the C4HCO website.

For a full list of QDP benefits that will be displayed on the C4HCO website refer to APPENDIX B: C4HCO MEDICAL DETAIL BENEFIT PAGE DISPLAY ORDER.

HOW TO ADD CUSTOM BENEFITS IN THE PLAN AND BENEFITS TEMPLATE

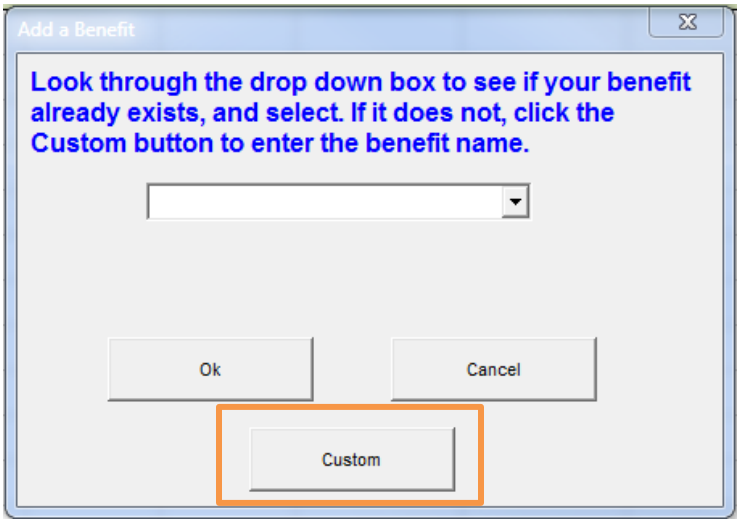
ADD CUSTOM BENEFIT: STEP 1

At the top of the Plans and Benefits Template, carriers will find and hit the "Add Benefits" button.



ADD CUSTOM BENEFIT: STEP 2

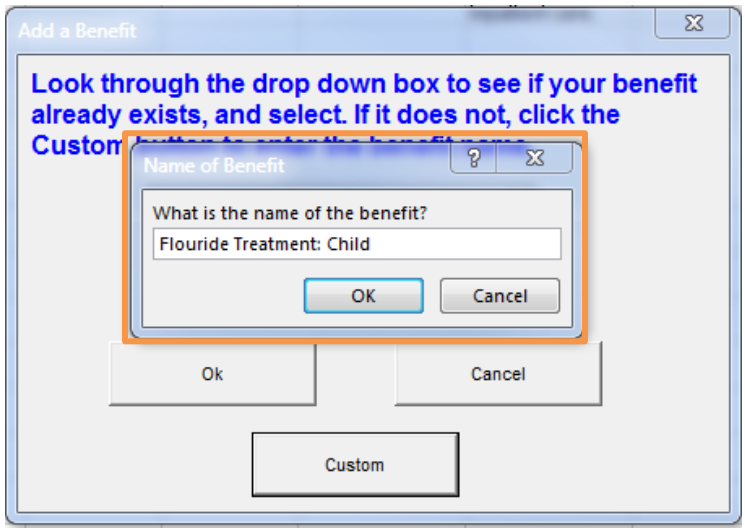
Carriers should now see the following pop-up box. Hit the "Custom" button.



ADD CUSTOM BENEFIT: STEP 3

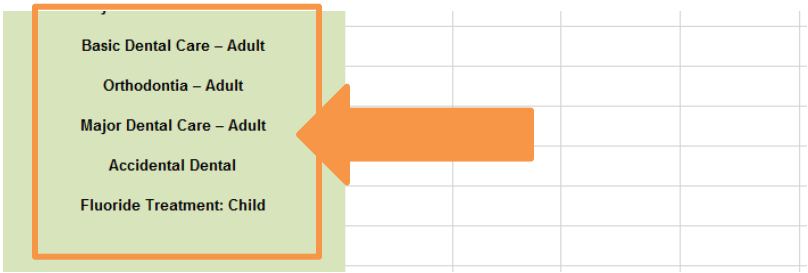
Carriers should now see the following pop-up box. Enter the name of the benefit using the **copy and**

paste function, from the Custom Benefits list below. Hit "OK".



ADD CUSTOM BENEFIT: STEP 4

The added benefit should now appear at the bottom of the list of benefits on the left-hand side of the template. Confirm that it has populated correctly.



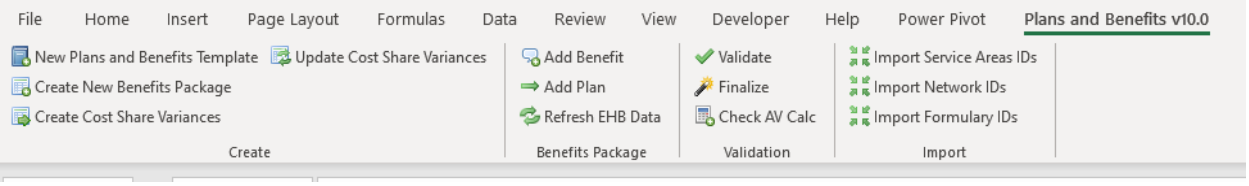
Custom Benefits
Oral Exams Child
X-rays Child
Fluoride Treatments Child

Cleaning Child
Oral Exams Adult
X-rays Adult
Fluoride Treatments Adult
Cleaning Adult
Resin (white plastic) Fillings Child
Sedative Fillings Child
Amalgam (steel) Fillings Child
Periodontics – Other Child
Resin (white plastic) Fillings Adult
Sedative Fillings Adult
Amalgam (steel) Fillings Adult
Periodontics – Other Adult
Oral Surgery Child
Implants Child
Dentures and Bridges Child
Root canal therapy Child
Medically Necessary Orthodontia Child
Oral Surgery Adult
Implants Adult
Dentures and Bridges Adult
Root canal therapy Adult

Please ensure these are entered EXACTLY as they appear above to avoid any objections after submission. **An objection will be issued to correct any misspellings.**

COST SHARE VARIANCE TAB INSTRUCTIONS: DENTAL CARRIERS

Once Carriers have completed the required sections on the "Benefits Package" tab including adding the custom benefits required, it is time to create a Cost Share Variance Tab. Hit the "Create Cost Share Variances" option.



COPAYMENT AND COINSURANCE: MEMBER RESPONSIBILITY

Copayment and coinsurance information displayed on the C4HCO website comes directly from the values carriers enter on the "Cost Share Variance" tab**. To be consistent with the QHPs displayed on C4HCO, carriers are required to populate the templates reflecting the member has cost sharing responsibility instead of the carrier's cost share responsibility.** For example, if for the "Fluoride Treatment: Child" benefit the dental carrier is responsible for 80% of the cost and the member for 20% of the cost, Carriers should list 20% in the coinsurance section.

COPAYMENT AND COINSURANCE: BEFORE / AFTER DEDUCTIBLE

If the copayment or coinsurance applies after the deductible or before the deductible, please use the appropriate dropdown option to indicate this nuance. The preferred dropdown options are $X Copayment with / after deductible OR X% Coinsurance after deductible. Please avoid using $X or X% when possible. This has caused customer confusion and may lead to a misinterpretation of the benefits.

USE ONLY IF DEDUCTIBLE APPLIES

Dental Check-Up for Children			
Copay		**Coinsurance**	
In Network (Tier 1)	*Out of Network*	*In Network (Tier 1)*	*Out of Network*
Not Applicable	Not Applicable	20.00% Coinsurance after deductible	No Charge

USE ONLY IF NO DEDUCTIBLE APPLIES

Dental Check-Up for Children			
Copay		**Coinsurance**	
In Network (Tier 1)	*Out of Network*	*In Network (Tier 1)*	*Out of Network*
Not Applicable	Not Applicable	20.00%	No Charge

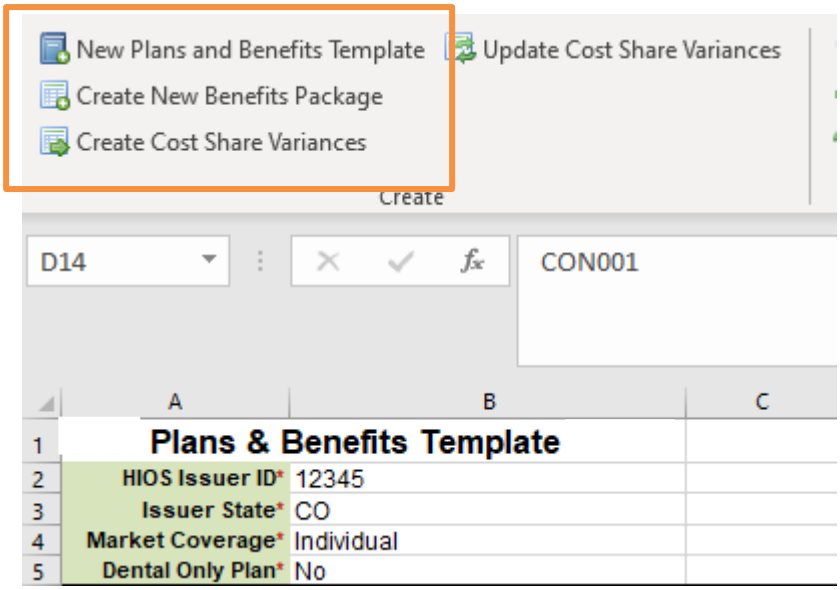
STAND-ALONE DENTAL: CHILD AND ADULT DEDUCTIBLES

C4HCO would like its plan detail pages to better accommodate the difference between child and adult deductibles. The proposed deductible descriptions are as follows:

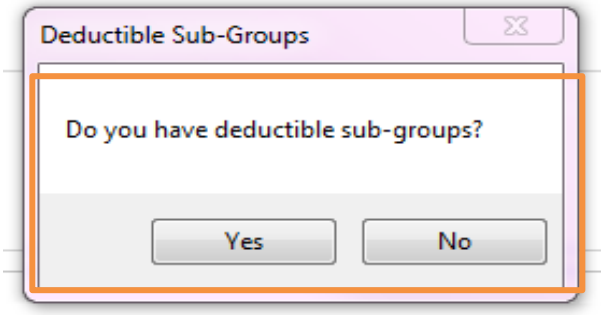
C4HCO Deductible Display	SERFF Template Deductible Display Cell
Dental EHB Deductible: Individual Child	Dental EHB Deductible - In Network Individual
Dental EHB Deductible: Children	Dental EHB Deductible - In Network Family
Dental Deductible: Individual Adult	Dental Deductible - In Network Individual
Dental Deductible: Family (Adult and Dependents)	Dental Deductible - In Network Family

For full details of the plan detail display, please see Appendix C: C4HCO Dental Detail Benefit Page Display Order. To gather this level of detail on the deductibles, C4HCO requires dental carriers to utilize the "Deductible Sub-Groups" functionality, which will allow the carriers to insert the data on the Cost Share Variance tab. Please follow the steps below:

STEP ONE: Once Carriers have completed adding all the benefit information on the "Benefits Package" tab and it is time to create a "Cost Share Variance tab", hit the Create Cost Share Variances button.

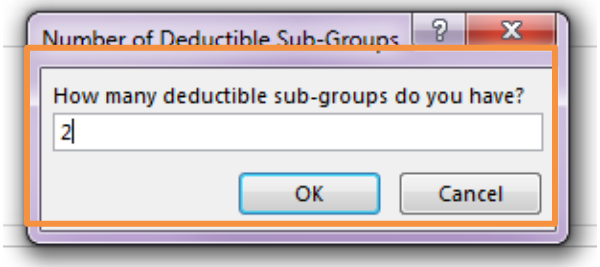


STEP TWO: A second pop-up box will appear "Deductible Sub-Groups" and ask, "Do you have deductible sub-group? Hit "YES."

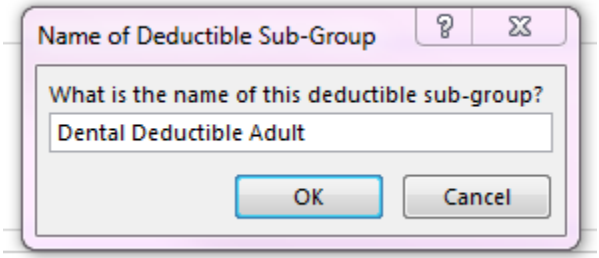


STEP THREE: The next pop-up box will appear "Number of Deductible Sub-Groups" and ask, "How many deductible sub-groups do you have?"

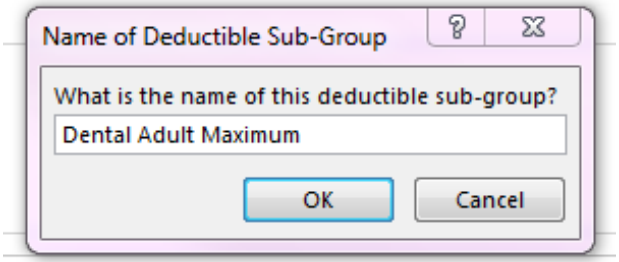
Insert 2.



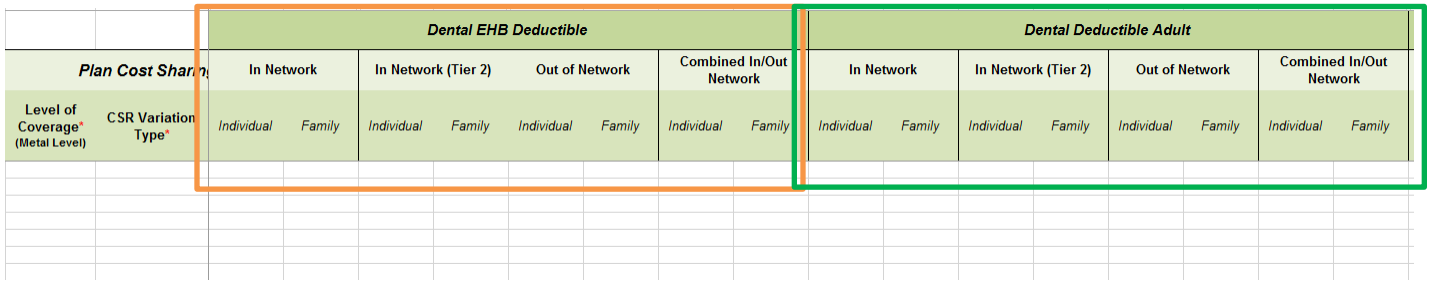
STEP FOUR: The next pop-up box will appear "Name of Deductible Sub-Group" and ask, "What is the name of this deductible sub-group?" enter Dental Deductible Adult.



Please use the following heading for the maximum amount the plan will pay for adult benefits under the plan.



The step for adding the additional "Dental Deductible: Adult" benefit section on the Cost Share Variance tab is complete. Populate all child level deductible amounts in the "Dental EHB Deductible" section and all adult level deductible amounts in the new "Dental Deductible Adult" section.



Plan Cost Shari		Dental EHB Deductible								Dental Deductible Adult							
		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Level of Coverage* (Metal Level)	CSR Variation Type*	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family

TRANSPARENCY IN COVERAGE TEMPLATE

This template will be completed and attached as a template under the Templates Tab.

For off-exchange issuers, please complete the first tab. Plan level data is not required for off-exchange carriers. After the question that asks if carriers were on-exchange in the previous year is answered as "No," please place "N/A" in the subsequent fields.

For on-exchange issuers, please complete the second tab completely with the appropriate listing of claims in each column.

Guidance may be found at:
https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage

RATE DATA TEMPLATE

The Rate Data template must be submitted under the Template Tab in the binder filing. To complete this tab, Carriers need the following:

- HIOS Issuer ID
- Federal TIN
- Rate Effective Date
- Rate Expiration Date
- Rating Method

IMPORTANT NOTE: Please submit a Rate Data template with reinsurance under the Supporting Documentation tab.

For SHOP plans, if they use quarterly trended rates, the effective date must coincide with the calendar days for each quarter. Each worksheet will have different effective dates.

Add sheets in the following scenarios:

- The issuer has SHOP plans with different rates effective and expiration dates; all plans in one worksheet must have the same effective dates
- When a SADP uses both family-tier and individual rating
- To separate the rating area
- The Rate Data Template must be submitted on the template tab in the binder filing. This template defines the premium rate that an issuer charges for each subscriber type that a plan covers.

Important for Stand-Alone Dental Plans: Please enter zeros and not 9999 where rates do not apply. This will cause an objection after submission.

Rates Table Template

All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.

Validate

Finalize

If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.

If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.

If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.

To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.

HIOS Issuer ID*	12345
Rate Effective Date*	1/1/2021
Rate Expiration Date*	12/31/2021
Rating Method*	Age-Based Rates

Add Sheet

Plan ID* Required: Enter the 14-character Plan ID	**Rating Area ID*** Required: Select the Rating Area ID	**Tobacco*** Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Age*** Required: Select the age of a subscriber eligible for the rate	**Individual Rate*** Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
12345CO1245789	Rating Area 1	No Preference	0-14	0.00
12345CO1245789	Rating Area 1	No Preference	15	0.00
12345CO1245789	Rating Area 1	No Preference	16	0.00
12345CO1245789	Rating Area 1	No Preference	17	0.00
12345CO1245789	Rating Area 1	No Preference	18	
12345CO1245789	Rating Area 1	No Preference	19	

https://www.qhpcertification.cms.gov/s/Rates

NO ADDITIONAL C4HCO REQUIREMENTS FOR QHPS OR QDPS.

PRESCRIPTION DRUG TEMPLATE

The Prescription Drug Template must be submitted on the Template Tab in the binder filing.
To complete this section, Carriers need the following:

- HIOS Issuer ID
- Issuer state
- Formulary URLs
- Formulary IDs (created within the template)
- RxNorm Concept Unique Identifiers (RxCUIs), along with their tier numbers, included in the drug lists

For all plans that comply with Colorado Insurance Regulation 4-2-58, carriers are required to have "RX Copay" in the name.

This section contains a template with two tabs: **Formulary Tiers** and **Drug Lists**.

A formulary consists of the cost sharing for each tier of drug benefits, along with an associated drug list, which defines the specific drugs included in the formulary.

Formulary Tiers

The **Formulary Tiers** tab allows Carriers to define the cost sharing for each formulary and associate each formulary with a drug list.

The **Drug Lists** tab allows Carriers to enter the specific drugs, along with tier placements, that are included in the formularies. A drug list can be linked to more than one formulary; a formulary can be linked to only one drug list. The Prescription Drug template links back to the Plans & Benefits template. Each plan in the Plans & Benefits template must list the formulary ID with which it is associated.

Important Note: Naming Conventions for plans with copays must include the in the plan marketing name: "**RX COPAY**" if that plan uses an all-copay structure.

Entering Drug Tiers

Per Colorado Insurance Regulation 4-2-58 Section 5.E., issuers must list their drugs covered under the medical benefit on their Prescription Drug template on its own tier.

Per Colorado Insurance Regulation 4-2-58 Section 5.D, Tier 1 must be the Preventive drug tier. Tier 2 must be the Lowest Cost tier. The tiers must continue to be entered from lowest cost sharing to highest cost sharing.

For detailed instructions on how to complete the Prescription Drug template, please see:

https://www.qhpcertification.cms.gov/s/Prescription%20Drugs

NO ADDITIONAL C4HCO REQUIREMENTS FOR QHPS OR QDPS.

NETWORK ID TEMPLATE

The Network ID Template must be submitted on the template tab in the binder filing.
For detailed instructions on how to complete the Network ID template, please see:

https://www.qhpcertification.cms.gov/s/Network%20ID

Data from the Network ID template is used to power the provider directory search tool on the C4HCO website. It will also be used during the shopping process and will be necessary for the validation of the ECP/NA Template.

For the C4HCO provider search tool to function and for the shopping display to be accurate, please ensure these instructions are followed when completing the template:

Network IDs: Carriers must use the same Network IDs in the Network Template as well as during the separate Provider Directory Data submission process to Treo. If Carriers change the ID of a network through the Network Template, carriers must ALSO change this ID in the submission to Treo. Failure to maintain a consistent ID may result in issues with the provider lookup tool for the products.
Network Name: On the Network Template under "Network Name", please enter that organization's standard Provider Network Name.
The network name Carriers provide on the template should be identical to the network name as it is used outside the C4HCO marketplace.
The Provider Network Name entered should be found when customers search for the network on the carrier's website. This would enable the customer to use the carrier's website for confirming their network and more accurately communicating their selected network to a provider.
Network names should NOT have a special exchange or marketplace indicators (e.g., an "x" for the exchange).

Network Template	All fields with an asterisk (*) are required.
Validate	To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.
Finalize	Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.
	Network IDs will populate in the drop-down box in Network ID column.
	Use each Network ID only once.
HIOS Issuer ID*	12345
Issuer State*	CO
Create Network IDs	

Network Name* Required: Enter the Network Name	Network ID* Required: Select the Network ID
The ABC Network	CON001
The XYZ Network	CON002

For the 2026 QHP Certification process, C4HCO will use the Provider Network template and continue to provide a network summary across all carriers for display to consumers. Carriers will be required to submit this data directly to C4HCO (i.e., do NOT plan to submit this in SERFF). For additional details on the Network Summary document, please contact Cliff Craig, Health Plan Account Manager, at ccraig@c4hco.com.

SERVICE AREA TEMPLATE

The Service Area Template must be submitted on the template tab in the binder filing, and consists of two parts:

- A template for identifying the counties in the issuer's service area, and the ZIP codes associated with the counties, if partial counties are identified, and
- A detailed partial county justification, as applicable.

For detailed instructions on how to complete the Service Area template, please see:

https://www.qhpcertification.cms.gov/s/QHP

NO ADDITIONAL C4HCO REQUIREMENTS FOR QHPS OR QDPS.

BUSINESS RULES TEMPLATE

The Business Rules Template must be submitted on the template tab in the binder filing.
For detailed instructions on how to complete the Business Rules template, please see:

https://www.qhpcertification.cms.gov

Individual & SHOP Business Rules

The Rules for Individual and SHOP will be entered into separate templates based on different rules between the Individual and SHOP markets. A template must be filed for Individual and SHOP in each binder if the carrier offers both market types.

ASSOCIATE SCHEDULE ITEMS TAB

Carriers will be required to complete the Associate Schedule Items Tab as part of the binder filing Requirements.

The Associate Schedule Items Tabs allows carriers to link submitted Rate and Form Schedule Items to each plan within a binder. This functionality eliminates the need for carriers to attach Rate and Form filing attachments to the binder's Supporting Documentation tab. The completion of this tab allows the DOI to view SERFF filing attachments without leaving the Plan Management workspace as binder filings are being reviewed, thus expediting the review process.

Instructions for completing the Associate Schedule Items tab are available on the SERFF website, under the "Help" section (click on "Help", select "User Manual" from the menu of available options, then click on "Appendix (Industry)."

In 2014, several carriers experienced difficulties when trying to complete this tab. According to SERFF, for carriers to be able to successfully associate rate and form filing submission with the binder, all three filings (rate, form, and binder) must be created under the same "instance" in SERFF.

NOTE: If Carriers are not able to complete this information, please provide a Note to Reviewer including the associated filing SERFF tracking numbers.

SUPPORTING DOCUMENTATION TAB

Quality Improvement Strategy (QIS)

Per the QHP Application Instructions, QIS data is collected for the 2026 plan year.

2026 Colorado Issuer ECP Attestation Template (State)

Colorado will use the 2026 Colorado Issuer ECP Attestation Template instead of the CMS SBE Attestation Form. All issuers who wish to offer either certified QHPs or SADPs in Colorado are required to respond to all attestation questions on the template and submit the signed 2026 Colorado Issuer ECP Attestation Template. The template can be found on the Supporting Documentation tab of the Binder and shall be attached to the Supporting Documentation Tab in the Binder filing.

Colorado HIOS Plan ID Crosswalk (State)

For the 2026 plan year, Colorado will use the Colorado Crosswalk instead of the Federal Crosswalk. The Colorado Crosswalk template can be found on the Supporting Documentation tab of the Binder. Carriers shall complete the State version of the Crosswalk template and submit it under the Supporting Documentation tab. All fields should be filled out. Please ensure that all plans filed and approved for PY2025 are listed on the crosswalk. For small group products, this includes any additional plans added during the 2025 plan year. All continuing plans and proposed new plans for 2026 must be on the crosswalk.

REMINDER FOR PY2026:

Carriers shall enter the "Type of Change for 2026", as this is a required field. Carriers that do not fill out this field will receive an objection and will be expected to correct the issue.

Colorado Silver Plan Crosswalk (State)

Please complete the 2026 Silver Plan Crosswalk and attach it under the Supporting Documentation tab. List ALL on-exchange silver plans (Standard Components only) with a CSR load and the on-exchange marketing name, as described in Colorado Insurance Bulletin B-4.100. Ensure the crosswalk lists the Substantially Similar silver off-exchange plan and marketing name for each on-exchange silver plan.

REMINDER: Carriers should *not* include any Silver plans that do not have a corresponding On-Exchange plan.

4-2-58 Formulary Compliance Template

These instructions provide guidance to carriers submitting the annual 4-2-58 Compliance Templates, as required by Colorado Insurance Regulation 4-2-58. These instructions apply to all carriers subject to the individual and group laws of Colorado, including non-grandfathered plans in the individual and small group markets. These instructions do not apply to carriers in the large group, student health insurance or short-term limited duration markets.

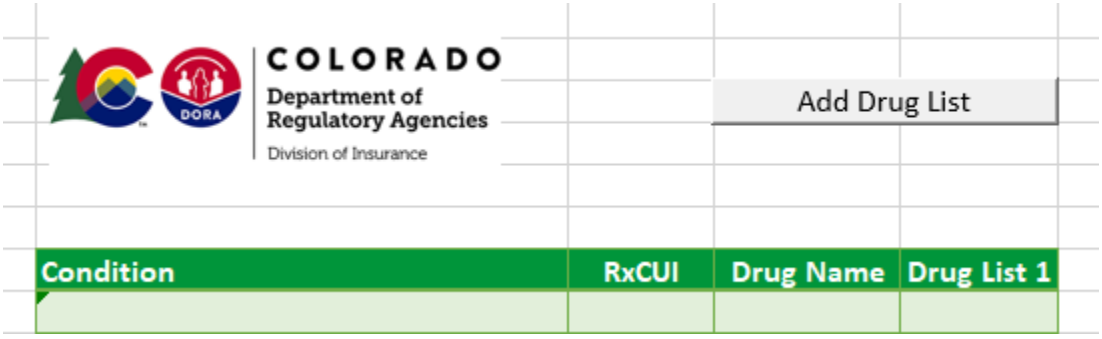
Carriers shall submit the 4-2-58 Formulary Compliance Template with the binders, by June 16, 2025.

As part of the filing, carriers must fill in the following tabs of the template completely:

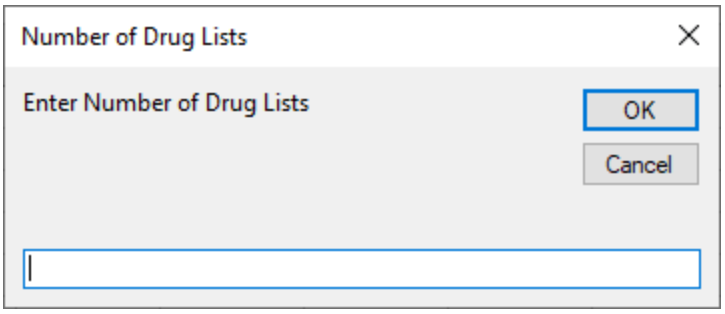
1. Formularies – carriers shall list all covered drugs associated with each of the identified 19 conditions. Carriers shall provide lists for all their drug lists.
2. Highest Cost Tier – carriers shall list all cost sharing arrangements for all plans, using the COF*** identifier.

Formularies (Drug Lists)

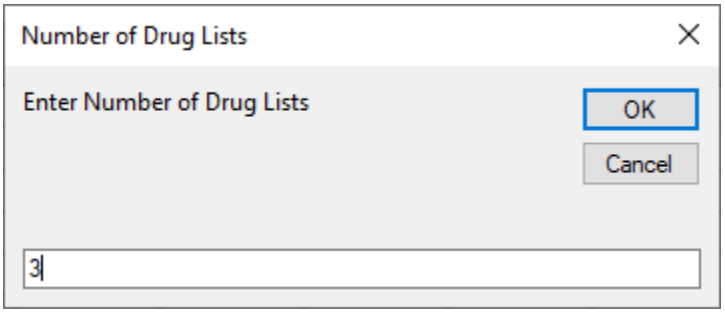
Carriers shall supply all formularies used in the individual or small group markets, depending on the market type for the filing. Carriers shall provide a list of the 19 conditions for each drug list utilized. To add additional drug lists (the template already contains Drug List 1), carriers should click on the "Add Drug List" Button.



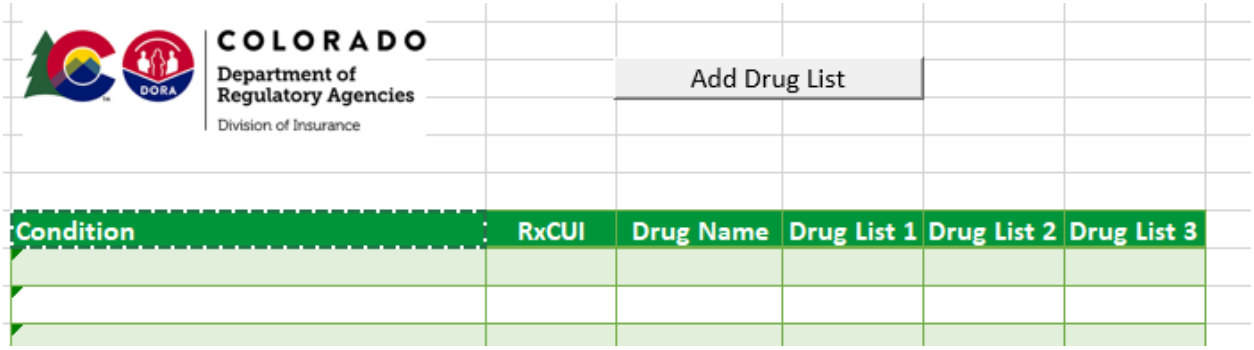
After clicking on the "Add Drug List", carriers should enter the total number of drug lists needed:



If the carrier has 3 drug lists, they should enter 3, as shown below:



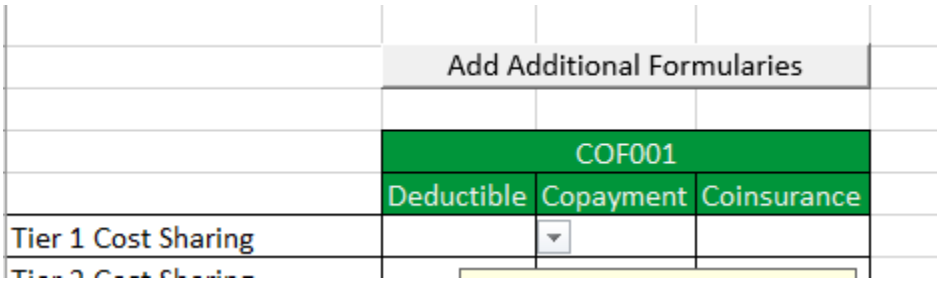
The template will automatically add Drug Lists 2 and 3, as shown in this example:



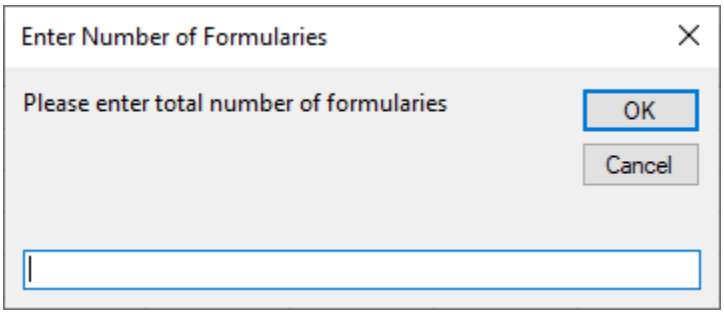
After adding the drug lists required, carriers shall fill in the condition, RxCUI, Drug Name and the tier number for each drug list. If a drug is not covered on all drug lists, the cell under that drug list should not have anything input into it, as the cells will only accept tiers 1 – 7.

Highest Cost Tier

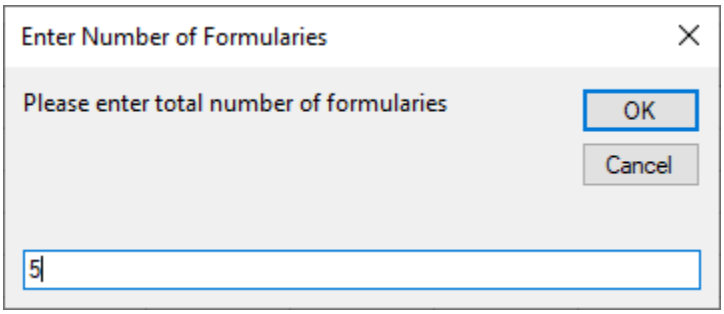
Carriers shall supply the Division with the highest cost tier for each of their plans, designated with the COF***. The template will automatically add the tiers required when carriers push the "Add Additional Formularies", as shown below.

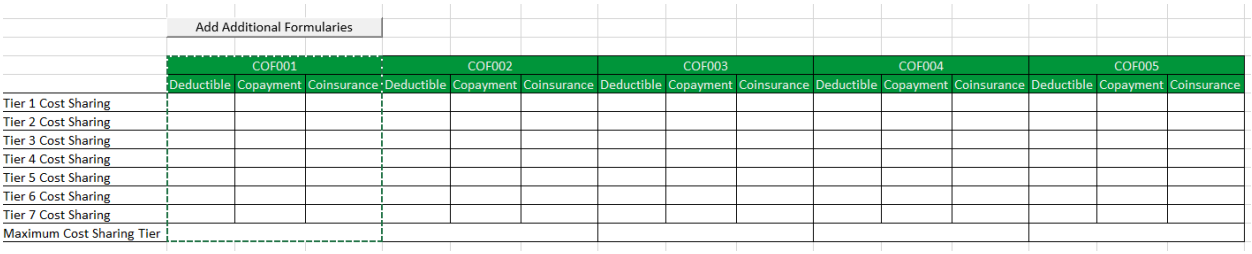


After clicking on the button, the carrier will enter the total number of formularies utilized, which will be added by the template. For instance, if the carrier has 5 formularies, the carrier should enter 5 in the box, as seen below:



Enter 5 in the box and the template will automatically add the appropriate number of formularies:





For the deductible fields, carriers shall enter "Y" or "N" for each tier that has cost sharing. Carriers shall enter the copayment in the copayment field and enter the consumer coinsurance in the coinsurance field.

In the last row, the carrier will enter the tier with the highest cost sharing. If two or more tiers have the same cost sharing, the carrier should enter the highest tier number in the Maximum Cost Sharing Tier, as it will only accept one tier.

NOTE: Please DO NOT delete any excess rows in the Highest Cost Tier tab. If the company does not have all seven tiers and deletes extra rows, this will cause an error when the Division runs its checks. For example, if there are five tiers, please leave Tier 6 through Tier 7 lines in the template. Leave the unnecessary rows blank.

	COF001		
	Deductible	Copayment	Coinsurance
Tier 1 Cost Sharing	N	$ -	0%
Tier 2 Cost Sharing	N	$ -	20%
Tier 3 Cost Sharing	N	$ -	20%
Tier 4 Cost Sharing	N	$ -	20%
Tier 5 Cost Sharing	Y	$ -	50%
Tier 6 Cost Sharing	Y	$ -	50%
Tier 7 Cost Sharing	Y	$ -	50%
Maximum Cost Sharing Tier	7		

Pharmacy Benefit Manager Collection Form (Confidential)

Pursuant to §10-16-122.1 C.R.S., the Division is collecting a list of all Pharmacy Benefit Managers (PBMs) the carrier contracts with or otherwise uses for claims processing services or other prescription drug or device services for the PY2026 year.

Reinsurance Care Management Protocol Assessment

All carriers eligible for the Colorado Reinsurance Program, established under House Bill 19-1168, are required to complete the Reinsurance Care Management Protocol Assessment. Please use the template on the Division's ACA Annual Filing Information / ACA Annual Filings / Binders.

JUSTIFICATIONS

For plan year 2026, the Division is requiring all applicable justifications to be included in the binder filing, rather than under the rate and form filing.

Certain justifications will be required for binder filings. Below is a listing of justifications, description of the justification and criteria. These can be found at https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.

- **EHB** – ***Substituted Benefit (Actuarial Equivalent) Justification***
  - Description
    - Identifies EHB benchmark benefits that have been substituted, the substituted benefits, and the associated values of each.
  - Criteria
    - This is required if any of the EHB Variance reasons in the plan and benefits template are marked as substituted.
- **Formulary - Inadequate Category/Class Count Supporting Documentation and Justification**
  - Description
    - Identifies reasons for an inadequate count in a category or class.
  - Criteria
    - Required if a drug count does not meet the benchmark and/or requirement for at least one drug covered per category.

Carriers offering plans that are found to have discriminatory plan designs during initial Division review may be asked to submit one or more of the following forms:

- **Discrimination** – ***Cost Sharing Outlier Supporting Documentation and Justification***
  - Description
    - Identifies reasons why cost sharing values found to be outliers should be allowed and are not discriminatory.

- Criteria
  - Required if cost sharing value is identified as an outlier at the national and state level.

❖ **Discrimination** – ***Language Supporting Documentation and Justification***
- Description
  - Identifies reasons why language identified as discriminatory should be allowed.
- Criteria
  - Required if language is found to be discriminatory.

❖ **Discrimination** – ***Drug Utilization Management Outlier Justification***
- Description
  - Identifies reasons why a category or class may be an outlier in terms of number of drugs that require utilization management but is not discriminatory.
- Criteria
  - Required if category or class is determined to be an outlier.

The Division will notify carriers of their need to complete one or more of these documents when and if issues are detected during the review period. The deadline for the submission of any supporting documentation or justifications will be made on a case-by-case basis.

❖ ***Unique Plan Design Supporting Documentation and Justification***
- Description
  - Describes the reasons that a plan qualifies as unique and the methods used to calculate actuarial value.
- Criteria
  - Required if Unique Plan Design is yes.

❖ ***Service Area Partial County Justification Cover Sheet***
- Description
  - Identifies justification for why entire counties will not be served.
- Criteria
  - This is required if carriers identify any counties that will be a partial county in the service area.

❖ ***Limited Cost Sharing Plan Variation – Estimated Advance Payment Supporting Documentation***
- Description
  - Certifies that an issuer has followed the CMS standards for developing limited cost share reduction (CSR) advance payment estimates.
- Criteria
  - Required for issuers that are requesting a CSR advanced payment for at least one limited cost sharing plan variation.

❖ ***Meaningful Difference Supporting Documents and Justification***
- Description
  - Describes the difference between plans to ensure they are unique from one another in cost sharing and network composition.

Criteria
- Required if there is not at least a 5% difference in cost sharing of the deductible and maximum out-of-pocket for each metal level and unique networks.

❖ ***Colorado ECP Justification Template***
- Description
  - Provides explanations for not meeting Colorado ECP standards and proposes corrective actions.
- Criteria
  - Required when at least one element of the ECP standards are not met, during ECP/NA Template validation.

CONNECT FOR HEALTH COLORADO REQUIRED DOCUMENTS: MEDICAL AND DENTAL

C4HCO provides important plan documentation to its customers during the shopping process. These documents are intended to enhance and support the benefit information displayed on the C4HCO website for use by customers, brokers, Health Coverage Guides, and other stakeholders.
For plan documents to appear on the C4HCO website they must be submitted by all carriers (medical and dental) on the "Supporting Documentation" tab in SERFF. All submissions are **due via the SERFF Binder on August 15, 2025.** Please follow all instructions below to submit the documents.

Carriers are expected to submit all written documentation at a **10th grade** reading comprehension level. A lower grade reading level is preferable but not required. All supporting document requirements are the **same for medical and dental** carriers. Any slight distinctions are noted in the table below.

The "Level" column indicates at which level of granularity for each document. The possible values and their definitions are as follows:

- **HIOS Standard Component Plan ID:** This document can apply to all cost share variations of a plan. When using this level, please put the standard component ID in the naming convention without the variant suffix.
- **HIOS Standard Component + Variant Plan ID:** This document must be specific to a single cost share variant of the plan. When using this level, please put the standard component ID with the variant suffix in the naming convention (e.g., HIOS Standard Component ID + Variant [-00, -01, -02, -03, -04, -05, -06, -07]). When submitting documents at this level, Carriers will have one document for the standard plan variant, another document for the no-cost sharing variant, etc. until all applicable cost share plan variants have their own version of this document.
- **Market Specific:** This document is applicable to all plans in each market. For example, it would be attached to all small group plans OR all individual plans, carriers do not need to include a plan ID in the naming convention.

❖ ***EOC Evidence of Coverage / COC Certificate of Coverage Forms***

EOCs/COCs Forms, approved by the Division in the Form filing, must be provided in English and in Spanish for every on-exchange plan for each variant level of the plan. The EOC/Policy forms will be submitted in the binder in SERFF at a date after reviews are completed, specified by the Division. Submission dates for Spanish EOCs will be determined between the Division and the carrier.

For Colorado Option Standardized Plans, EOCs must be provided in English and Spanish for every variant level, including -00 and -07 variants, of every plan, both on-exchange and off-exchange.

The addendum with language taglines in the top 15 languages spoken by the LEP populations of Colorado must be attached to the EOCs and the SBCs.

Carriers must ensure that the Division-approved co-branded logo, which uses both the Colorado Option logo and the carrier's logo to form a dual logo that is a single image, is on all individual and small group CO Option Standardized Plan EOC/COC forms.

For Plan Year 2026, please utilize zipped files to upload SBCs on the Supporting Documentation tab under the appropriate user-added heading for the English and Spanish translated plan level EOCs.

- ***Summary of Benefits and Coverage (SBC) and Colorado Supplement to the Summary of Benefits and Coverage (COSSBC) Forms***

At a time specified by the Division, after Division review, and during the finalization of 2026 plans and rates, variant-specific SBCs and COSSBCs will be submitted in the Binder filings for transfer to C4HCO. SBC and COSSBC documents for all plans offered through C4HCO, must be attached under the Supporting Documentation tab of the binder.

Instructions for preparation of SBC and COSSBC documents are being moved to a separate Instruction document. Instructions for submissions in the Form filings and the more detailed submissions in the Binder filings will now appear in Colorado's ACA SBC/COSSBC Filing Procedures for 2026.

For the individual market, Colorado Option Standardized Plans, SBCs must be provided in English and Spanish for every variant level of every plan for both on-exchange and off-exchange, including the -00 and -07 variant. Small Group market carriers shall provide English versions of each Colorado Option Standardized Plan. The addendum with language taglines in the top 15 languages spoken by the LEP populations of Colorado must be attached to the EOCs and the SBCs.

Carriers offering plans through C4HCO must submit COSSBC forms in English and Spanish for every on-exchange individual plan, and every individual and small group Colorado Option Standardized Plan, both on-exchange and off-exchange. COSSBCs can be prepared at the variant level, or at the plan level if there are no differences between the variants.

Carriers must ensure that the Division-approved co-branded logo, which uses both the Colorado Option logo and the carrier's logo to form a dual logo that is a single image, is on all individual and small group CO Option Standardized Plan SBC and COSSBC forms.

For Plan Year 2026, please utilize zipped files to upload SBCs on the Supporting Documentation tab under the appropriate user-added heading for the English and Spanish translated plan level SBCs and COSSBCs.

As part of the SBC submissions for the 2026 plan year, carriers are required to submit PDFs of the SBC Calculator, showing the calculation of the three (3) scenarios. Carriers shall submit this for the Colorado Option plans only. The calculations must match the Plans and Benefits Template Coverage Examples. These coverage examples will be submitted in the Binders under the Supporting Documentation tab under its own heading. (These documents will not be going to C4HCO.)

Dental carriers should use the current standard dental SBC template developed by C4HCO. The COSSBC Form is not required for Dental filings.

Carrier Corrections Worksheet and Over-the-Shoulder Reviews with C4HCO

When C4HCO conducts its Over-the-Shoulder reviews, the Division issues a reminder to complete the Carrier Corrections Worksheet. This template is designed to hold all requested changes to the Plans and Benefits template and any accompanying documents affected by the PBT changes including the SBCs/EOCs/COSSBCs.

What Not to Submit on This Worksheet

The Carrier Corrections Worksheet is designed for template and document changes in the binder. If the company identifies any changes required in other ACA filings, the company should reach out directly in that filing. For example, if there are corrections/revisions required for the Forms, first, a **Note to Reviewer** should be submitted within that specific filing. An email to the primary reviewer should be a secondary form of communication to request any changes be submitted to the forms.

****NOTE: The benefits and cost shares in the form filings MUST match the information entered in the Plans and Benefits template.**

	Document	Description	Required?	Language (s)	Format	Level	File Naming Convention
1	**Evidence of Coverage/ Certificate of Coverage Form in English**	Please attach either the Evidence of Coverage or the Certificate of Coverage Form. This document will also be accessible from the C4HCO plan detail page. **Dental Carriers** may know this document as the Schedule of Benefit / Plan Details booklet.	Yes	English	PDF	Standard Component + Variant Plan ID	EOC_ENG_CarrierName_StandardComponent+VariantID_YYYYMMDD.pdf
2	**Evidence of Coverage/ Certificate of Coverage Form in Spanish**	Please attach either the **Evidence of Coverage/ Certificate of Coverage Form**. If attached, this document will also be accessible from the C4HCO plan detail page. Because the Policy Form is a contract between the carrier and the customer.	Yes for all Individual plans	Spanish	PDF	Standard Component + Variant Plan ID	EOC_ENG_CarrierName_StandardComponent+VariantID_YYYYMMDD.pdf
3	**Summary of Benefits & Coverage (SBC) in English**	Please attach the Summary of Benefits and Coverage (SBC) PDF file specific to the Standard Component + Variant ID using the federal 2021 SBC template. The SBC must include the taglines specified by CMS. **Dental carriers** should use the current standard template developed by C4HCO.	Yes	English	PDF	Standard Component + Variant Plan ID	SBC_ENG_CarrierName_StandardComponent+VariantID_YYYYMMDD.pdf

4	**Summary of Benefits & Coverage (SBC) in Spanish**	Please attach the Summary of Benefits and Coverage (SBC) PDF file specific to the Standard Component + Variant ID. The SBC should be in the Spanish language and at a 10th grade reading level. **Dental carriers** should use the current standard template developed by C4HCO.	Yes	Spanish	PDF	Standard Component + Variant Plan ID	SBC_SPNSH_CarrierName_StandardComponent+VariantID_YYYYMMDD.pdf
5	**Colorado Supplement to the Summary of Benefits and Coverage Form in English**	Please attach the Colorado Supplement to the Summary of Benefits and Coverage Form specific to the Standard Component ID using the template available in Colorado Insurance Regulation 4-2-20.	Yes	English	PDF	Standard Component ID	COSSBC_ENG_CarrierName_StandardComponentID_YYYYMMDD.pdf
6	**Colorado Supplement to the Summary of Benefits and Coverage Form in Spanish**	Please attach the Colorado Supplement to the Summary of Benefits and Coverage Form specific to the Standard Component ID using the template available in Colorado Insurance Regulation 4-2-20.	Yes	Spanish	PDF	Standard Component ID	COSSBC_ENG_CarrierName_StandardComponentID_YYYYMMDD.pdf

APPENDIX A: C4HCO MEDICAL DETAIL BENEFIT PAGE DISPLAY ORDER

C4HCO has a web page for every Qualified Health Plan (QHP). These pages have categories and detailed plan and benefit information that comes directly from the carrier's submission on the Plan and Benefits Template. The categories, which are defined by C4HCO, are the blue rows in the table below. The other pieces of information come directly from the PBT template or from the supporting documents. Most benefits show the relevant copayments, coinsurance, limits, and exclusions.

Benefit Name / Preferred Display Order
General Details - C4HCO Benefit Category
Combined Medical and Drug EHB Deductible - Individual
Combined Medical and Drug EHB Deductible - Family
Maximum Out of Pocket for Medical and Drug EHB - Individual
Maximum Out of Pocket for Medical and Drug EHB -Family
Plan Documents - C4HCO Benefit Category
Summary of Benefits and Coverage - English
Summary of Benefits and Coverage -Spanish
Colorado Supplement to the Summary of Benefits and Coverage – English
Colorado Supplement to the Summary of Benefits and Coverage – Spanish
Company Profile - English
Company Profile - Spanish
Quality Overview - English
Quality Overview - Spanish
Marketing Brochure - English
Marketing Brochure - Spanish
Membership agreement / Evidence of Coverage
Provider Network
Provider Office Visits - C4HCO Benefit Category
Preventive Care/Screening/Immunization
Primary Care Visit to Treat an Injury or Illness
Specialist Visit

Primary Care Telehealth Visit
Specialist Telehealth Visit
Prescription Drugs - C4HCO Benefit Category
Generic Drugs
Preferred Brand Drugs
Non-Preferred Brand Drugs
Specialty Drugs
Facilities - C4HCO Benefit Category
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services
Inpatient Hospital Services (e.g., Hospital Stay)
Inpatient Physician and Surgical Services
Maternity - C4HCO Benefit Category
Prenatal and Postnatal Care
Delivery and All Inpatient Services for Maternity Care
Emergency Care - C4HCO Benefit Category
Urgent Care Centers or Facilities
Emergency Room Services
Mental Health Benefits - C4HCO Benefit Category
Mental/Behavioral Health Office Visit
Mental/Behavioral Health Outpatient Services
Mental/Behavioral Health Inpatient Services
Substance Abuse Disorder Office Visit
Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Inpatient Services
Testing - C4HCO Benefit Category
Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging
Imaging (CT/PET Scans, MRIs)

Medical Devices - C4HCO Benefit Category
Durable Medical Equipment
Prosthetic Devices
Habilitative and Rehabilitative Services - C4HCO Benefit Category
Habilitative Services
Outpatient Rehabilitative Speech Therapy
Outpatient Rehabilitative Occupational Therapy
Outpatient Rehabilitative Physical Therapy
Home Care & Hospice - C4HCO Benefit Category
Home Health Care Services
Hospice Services
Additional Benefits - C4HCO Benefit Category
Chiropractic Care
Bariatric Surgery
Infertility Services

APPENDIX B: C4HCO DENTAL DETAIL BENEFIT PAGE DISPLAY ORDER

C4HCO has a web page for every Qualified Dental Plan (QDP). These pages have categories and detailed plan and benefit information that comes directly from the carrier's submission on the Plan and Benefits Template. The categories, which are defined by C4HCO, are the blue rows in the table below. The other pieces of information come directly from the PBT template or from the supporting documents. Most benefits show the relevant copayments, coinsurance, limits, and exclusions.

Benefit Name / Preferred Display Order
General Details - C4HCO Benefit Category
Dental EHB Deductible - Individual Child
Dental EHB Deductible - Children
Maximum Out of Pocket for Dental EHB - Individual Child
Maximum Out of Pocket for Dental EHB - Children
Dental EHB Deductible - Individual Adult
Dental EHB Deductible - Family Adult
Maximum Out of Pocket for Dental EHB - Individual Adult
Maximum Out of Pocket for Dental EHB -Family Adult
Plan Documents - C4HCO Benefit Category
Dental Summary of Benefits and Coverage
Benefit Description / Marketing Brochure - English
Benefit Description / Marketing Brochure - Spanish
Company Profile – English
Company Profile –Spanish
Membership agreement / Evidence of Coverage
Dental Provider Network Template
Diagnostic and Preventive Services Child - C4HCO Benefit Category
Oral Exams Child
X-rays Child
Fluoride Treatments Child
Cleaning Child
Diagnostic and Preventive Services Adult - C4HCO Benefit Category
Oral Exams Adult

X-rays Adult
Fluoride Treatments Adult
Cleaning Adult
Basic Services Child - C4HCO Benefit Category
Resin (white plastic) Fillings Child
Sedative Fillings Child
Dentures and Bridges Adult
Root canal therapy Adult
Amalgam (steel) Fillings Child
Periodontics – Other Child
Basic Services Adult - C4HCO Benefit Category
Resin (white plastic) Fillings Adult
Sedative Fillings Adult
Amalgam (steel) Fillings Adult
Periodontics – Other Adult
Major Services Child - C4HCO Benefit Category
Oral Surgery Child
Implants Child
Dentures and Bridges Child
Root canal therapy Child
Medically Necessary Orthodontia Child
Major Services Adult - C4HCO Benefit Category
Oral Surgery Adult
Implants Adult
Dentures and Bridges Adult
Root canal therapy Adult