Colorado's ACA Form Filing Instructions for 2026

April 28, 2025 (revised May 1, 2025)

Contents

INTRODUCTION

The purpose of this document is to provide carriers with guidance on ACA health benefit plan form filing instructions, and to ensure that forms documentation for ACA health benefit plans is submitted properly, and efficiently through SERFF, pursuant to § 10-16-107.2, C.R.S., Colorado Insurance Regulation 4-2-41, and federal and state laws and regulations.

For the 2026 plan year, the Colorado Division of Insurance (Division) and Connect for Health Colorado (C4HCO), also known as "the exchange," have jointly prepared filing instructions for ACA health benefit plan filing submissions. Instructions are provided for each filing type (rate, form, SBCs, MHPAEA, network adequacy, and binders), and may be accessed on the Division website at https://doi.colorado.gov/insurance-industry/health-insurance-information-for-industry.

Instructions or requirements for forms that are specific to C4HCO are clearly marked with the C4HCO logo.

Carriers offering individual and small group health benefit plans, on and off the exchange, with an effective date of January 1, 2026, are required to submit form filings to the Division no later than May 12, 2025.

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

All dates are subject to change.

APPLICABILITY

These instructions are intended for all carriers offering individual and small group ACA health benefit plans on and off the Exchange.

Carriers offering stand-alone dental plans (SAPDs) that provide for pediatric dental as an essential health benefit should refer to the Division's "Colorado ACA SADP Filing Instructions for Plan Year 2026" document for forms instructions, available on the Division website at ACA Annual Filing Types/Forms/Instructions.

NEW ITEMS/CHANGES for PLAN YEAR 2026 FILINGS

On March 10, 2025, the Centers for Medicare and Medicaid Services (CMS) issued the **2025 Marketplace Integrity and Affordability Proposed Rule**. The Division is monitoring this proposed federal rule and current legislation at the state level and will provide guidance to carriers with possible revisions to form filings as they become available.

The Division has developed the required language for some of the benefits that have been revised or added based on federal and state laws. For the 2026 plan year, the Division has provided the language and the section of the forms below.

NOTE: RED text signifies new information for plan year 2026.

FORM FILINGS

Please remember, the following elements apply to all filings:

ESSENTIAL HEALTH BENEFITS

Per state and federal regulations, ALL non-grandfathered health benefit plans offered in the individual and small group markets on and off the Exchange must cover the "essential health benefits" (EHBs).
EHBs are based on the state-selected benchmark plan.

For the 2026 plan year, the Colorado Kaiser HMO plan used in 2017 with additional EHBs approved by CMS in 2021, and the Colorado CHP+ Dental Plan will serve as the benchmark plans for defining medical and pediatric dental EHBs, respectively. The EHB requirements, including Substitution of Benefits, are presented in Colorado Insurance Regulation 4-2-42.

The CHP+ Dental Plan is the same benchmark plan used in the 2017 through 2025 plan years.
EXCLUDED BENEFITS (INCLUDING ABORTION):
Per federal law (45 C.F.R. 156.115(d)), the following benefits are excluded from EHBs, even though the EHB-benchmark plan may cover them:

- routine non-pediatric dental services;
- routine non-pediatric eye exam services;
- long-term/custodial nursing home care benefits; and/or
- non-medically necessary orthodontia.

Additionally, while the EHB-benchmark plan may cover abortion services, pursuant to section 1303(b)(1)(A) of the ACA (45 C.F.R. 156.115(c)), a carrier is not required to cover these services as part of the requirements to cover EHB.

C.R.S. 10-16-104(26) requires that all individual and group health benefits plans issued or renewed in this state cover the total cost of abortion care.

DISCRIMINATION

Per state and federal regulations, carriers may not offer health benefit plans that:

1) Either through their benefit design or the implementation of that benefit design discriminate against individuals on the basis of age, expected length of life, presence of predicted disability, degree of medical dependency, quality of life, or other health conditions;
2) Discriminate against individuals on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation;
3) Establish rules of eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability, and other health status-related factors deemed appropriate by the Secretary of Health and Human Services;

4) Discriminate against any provider operating within their scope of practice; or
5) Discriminate against individuals or employers based on whether:
   - they receive subsidies; or
   - they provide information to state or federal investigators who cooperate in the investigation of a violation of the Fair Labor Standards Act

NOTE: The prohibitions against discrimination listed above ARE SEPARATE AND DISTINCT FROM THE PROHIBITIONS AGAINST DISCRIMINATORY COST-SHARING PROVISIONS, which will be evaluated as part of the Division's rate review process.

FOR DETAILED INFORMATION ABOUT THE PROCESS FOR IDENTIFYING DISCRIMINATORY COST-SHARING ARRANGEMENTS, PLEASE SEE THE DIVISION'S "COLORADO ACA RATE FILING INSTRUCTIONS FOR 2026" when they become available in mid-May.

CONSUMER PROTECTION AND TRANSPARENCY REQUIREMENTS

Under the ACA, health insurance carriers seeking certification of health benefit plans must make accurate and timely disclosures of certain information to the appropriate Exchange (if applicable), the Secretary of HHS, and the state insurance commissioner, and make it available to the public.

MEANINGFUL ACCESS

ACA health benefit plan carriers must include an addendum with language taglines in the top 15 languages spoken by the limited English proficient (LEP) populations of that state on significant documents. Evidence of Coverage, Certificates, and Summaries of Benefits and Coverage are considered significant documents and must include the taglines addendum.

Educational, marketing, and plan materials must comply with the requirements for meaningful access for individuals with limited English proficiency and for people with disabilities. ACA health benefit plan carriers are required to provide a Summary of Benefits and Coverage (SBC) and uniform glossary to current enrollees as well as to individuals and small employers seeking insurance.

SPECIFIC SECTIONS AND LANGUAGE REQUIRED FOR PLAN YEAR 2026 FORM FILINGS

All Form filings for the 2026 plan year are required to include the following sections and language as specified in Colorado statutes and regulations. Specific language requirements are *italicized*. Some of these have been revised from previous years. The Division will review submitted documents to verify the specific language below has been included. Please revise existing language where necessary.

CONTRACEPTIVE COVERAGE

Pursuant to § 10-16-104(18) C.R.S., § 10-16-104.2, C.R.S., 45 C.F.R. § 147.130, and Colorado Insurance Regulation 4-2-95, carriers will explicitly state in the Certificate of Coverage and/or Evidence of Coverage the language noted below describing coverage requirements to members contraceptive coverage.

The carrier shall include:

1) An explanation to consumers and enrollees of its easily accessible, transparent, sufficiently expedient, and not unduly burdensome exceptions process to obtain, without cost to the

enrollee, non-formulary or non-preferred contraception as determined necessary by the enrollee's provider. This will include a link to the carrier's exceptions process and any public- facing information describing how to complete this exceptions process.

2) A notice regarding coverage of a twelve (12) month supply of a contraceptive in the carrier's consumer-facing formularies.

3) A notice in the carrier's consumer-facing formularies if certain contraceptives, such as IUDs and implants, are provided under the medical benefit rather than the pharmacy benefit. The exact language to include in the Certificates of Coverage and/or Evidences of Coverage is:

We cover all FDA-approved, cleared, or granted exception, including the eighteen (18) forms of emergency and preventive contraception approved by the FDA, and included in the Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines, at no-cost to plan enrollees. These include: tubal ligation, various intrauterine devices (IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method). Over the counter and emergency contraception is also covered at no-cost, with or without a prescription.

We cover twelve (12) months of a contraceptive at one time.

While We may utilize certain medical management techniques to prioritize coverage of one medication or item in the same category, these techniques cannot create unreasonable delay and no plan enrollees will be subject to any of the following: Denials of coverage for all or a particular brand name of contraceptives, fail-first or step therapy requirements, or age limitations on coverage.

If you require a different type of contraception, We will cover, without cost to the enrollee, any necessary contraceptive service or item, and the Company will defer to your provider's determination. We have an exceptions process to request a different type of contraception that is easily accessible, transparent, sufficiently expedient, and not unduly burdensome on You or your provider. More information about the exceptions process can be found here [Carrier will insert a public facing link to its exception process and any public-facing information describing how to complete this exceptions process here].

GENDER DYSPHORIA AND GENDER AFFIRMING CARE

Pursuant to § 10-16-104(5.5)(I)(A) and Colorado Regulations 4-2-64, and 4-2-62.5.E.3, carriers shall state the coverage requirements for the treatment of gender dysphoria and gender affirming care in the Certificate of Coverage and/or Evidence of Coverage pertaining to medically-necessary physical and behavioral health services, including but not limited to office visits, counseling, preventive health, hormone therapies, prescription drugs, laboratory services, and surgical procedures, including pre- and post-operative care.

Carriers shall indicate they will not deny, exclude, or otherwise limit gender affirming care coverage for medically necessary services, in accordance with generally accepted professional standards of care, based upon sexual orientation or gender identity.

Any exclusionary language for cosmetic surgery procedures must clearly indicate "except services for medically necessary gender affirming care."

Carriers shall explicitly list each of the specific medically necessary surgical procedures covered to treat gender dysphoria, as listed on the Binder Gender Dysphoria template, Appendix A of these procedures, and provide a listing of all gender-affirming care exclusions, including specific non-covered surgical procedures, as listed as not covered on the Binder Gender Dysphoria template. Each of the 58 surgical procedures identified in Appendix A must appear on the list of covered services or the list of excluded services.

COVERAGE FOR HIV PRE-EXPOSURE PROPHYLAXIS AND TREATMENT COVERAGE

Pursuant to §10-16-152(2) C.R.S., §10-16-109 (C.R.S.) and Colorado Regulation 4-2-73, Carriers shall state the coverage requirements for human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) and shall include the following language:

In Section 7: What is Covered - Preventive Care Services

Coverage is provided for HIV pre-exposure prophylaxis (PrEP), including baseline and monitoring services consistent with USPSTF recommendations, for federal Food and Drug Administration (FDA)-approved medications without copayment, coinsurance, or other cost-sharing.

FDA approved HIV PrEP medications listed on our formulary are not subject to step therapy or prior authorization requirements. Non-formulary FDA approved HIV PrEP medications are not subject to step-therapy or prior authorization when prescribed or dispensed by a pharmacist. Requests from a non-pharmacist for FDA-approved non-formulary HIV PrEP medications shall be processed on an urgent basis within 24 hours of receipt.

In Section 7 - What is Covered - Prescription Drugs, Supplies, and Supplements

Pursuant to §10-16-152(2) C.R.S., Carriers shall explicitly state FDA approved HIV treatment medications listed on formulary are not subject to prior authorization or step-therapy.

COVERAGE FOR SUBSTANCE USE DISORDERS (SUD)

The carrier shall include the following benefit language (Note: contents in brackets for this paragraph are caveats to consider and are not required to be included):

Coverage is provided for treatment of a substance use disorder regardless of whether the treatment is voluntary, or court-ordered as a result of contact with the criminal justice or legal system [if the Carrier provides coverage for treatment of a substance use disorder]. *Coverage includes, at a minimum, benefits that are medically necessary and otherwise covered under the plan. Such coverage is subject to copayment, deductible, and policy maximums and limitations.* [Health benefit plans issued by an entity subject to the provisions of C.R.S part 4 of Title 10, Article 16 may provide that the benefits required pursuant to this section are covered benefits only if the services are deemed medically necessary and are rendered by a provider who is designated by and affiliated with the health maintenance organization.]

MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDERS (SUD)

The carrier shall include the following benefit language:

In Section 7 - What is Covered – Mental Health

Medication-Assisted Treatment (MAT), a combination of behavioral therapies and medications approved by the FDA to treat substance use disorders (SUD), is a covered benefit. This coverage includes services provided by Opioid Treatment Programs (OTPs) for methadone administration

and maintenance for the treatment of opioid use disorder (OUD)

In Section 7 - What is Covered - Prescription Drugs, Supplies, and Supplements

Prior authorization and step therapy are not required or applied to any FDA-approved prescription drug listed on our formulary for the treatment of SUD's, including alcohol use disorder, opioid use disorder, and tobacco use disorder. At least one FDA approved medication for the treatment of each DSM-5 defined SUD condition is available on the lowest-cost tier of the formulary.

AUTISM SPECTRUM DISORDER

The following statement must be included in Section 7 in benefit descriptions for Autism Spectrum Disorder and Therapies:

Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are Medically Necessary to treat Autism Spectrum Disorder.

BODY MASS INDEX (BMI)/IDEAL BODY WEIGHT (IBW)

Pursuant to §10-16-166, **in Section 7 - What is Covered – Mental Health,** the carrier shall include the following language: *The use of Body Mass Index (BMI) or Ideal Body Weight (IBW) or any other standard requiring an achieved weight will not be utilized to determine medical necessity or level of care appropriateness of the treatment of eating disorders, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.*

BMI or IBW will not be a determining factor when assessing medical necessity or level of care appropriateness for treatment of anorexia nervosa, restricting subtype, or binge-eating/purging subtype as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

OTHER SPECIFIC COVERAGES

The Division will also be reviewing forms for additional items including, but not limited to, those listed below:

- Explanation for prescription insulin drug cost-sharing and limitations, as presented in Colorado Insurance Regulation 4-2-68;
- Mental Health Parity (MHPAEA) requirements as presented in Colorado Insurance Regulation 4- 2-64 and in MHPAEA filings;
- Coverage for SUD treatment regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice system as specified in §§10-16-104.7 C.R.S.
- Prescription drug step therapy protocols as specified in §§10-16-145 and 10-16-145.5 C.R.S.
- A description of cost sharing requirements when calculating a covered person's overall contribution to an out-of-pocket maximum. Include a statement about how rebates, discounts, and coupons are applied to the out-of-pocket maximum as required under Senate Bill 23-195.
- Statements in EOCs/COCs concerning compliance with §§10-16-704(3) and 10-16-704(5.5) C.R.S. and Colorado Insurance Regulation 4-2-67 regarding out-of-network cost-sharing;
- Statement in the EOC/COC clarifying no covered person will be denied coverage for

medical/surgical or behavioral, mental, or substance use disorder care as a result of self-harm or suicide attempt or completion, pursuant to §§ 10-16-104(5.5) C.R.S.;
- Clear descriptions in EOCs and SBCs when specific cost-sharing or treatment limits apply to multiple services/benefits;
- Statement of copay cap on epinephrine auto-injector coverage as described in §10-16-160 C.R.S.;
- Confirmation that plans are in compliance with "No Surprises Act" requirements;
- Confirmation that prosthetic devices will be provided if the treating physician determines the prosthetics are necessary for physical and recreational activities per §10-16-104(14)(II) C.R.S.; and
- Any new Colorado State Legislation signed into law requiring changes to ACA health benefit plans.

ADDITIONAL SPECIFIC SECTIONS AND LANGUAGE REQUIRED FOR PLAN YEAR 2026 **COLORADO OPTION STANDARDIZED PLANS** FORM FILINGS

All Form filings specifically for plan year 2026 **Colorado Option Standardized plans** will be required to include the following sections and language as specified in revised and additional statutes and regulations.

DIABETIC SUPPLIES - **COLORADO OPTION STANDARDIZED PLANS**

Carriers shall include a link to the website that outlines coverage of diabetic supplies with $0 cost-sharing and not subject to a deductible in all Colorado Option plans (required in Colorado Emergency Regulation 25-E-01 and Colorado Insurance Regulation 4-2-81) in their Certificates of Coverage and/or Evidences of Coverage. The Division will be sharing a mockup of how it expects these websites to be displayed to align with the regulatory requirements and will be reviewing carriers' websites against these requirements.

SERFF FORM FILING SUBMISSION REQUIREMENTS

The following information must be completed in SERFF for form filing submissions to be considered complete.

INITIAL FILING QUESTIONS IN SERFF (when creating a filing):

Filing Company - Name entered under this field MUST match "Name of Entity" on the *Certificate of New Forms*

TOI - See Appendix A of this document for a complete listing of ACA-related TOI codes. All filings submitted using these codes are considered ACA filings.

Sub-TOI - See Appendix A for a complete listing of ACA-related Sub-TOI codes. Please use the most specific Sub-TOI code available for the filing (i.e., please use the code that indicates whether the plan is a PPO, POS, EPO, or HMO, as applicable, rather than using the "Other" code)

Filing Type - Select "Form"

GENERAL INFORMATION TAB

ACA - Select "Non-grandfathered" – For filings submitted under an ACA-related TOI, "Not ACA-Related" is not a valid selection for this field and will result in an immediate objection.

Product Name - Carriers are free to create their own product names; however, the Division and CMS request using marketing names that use correct information, are as descriptive as possible (i.e., including if a product is on- or off-exchange, includes or excludes pediatric dental benefits, etc.), without omission of material fact, and do not include content that is misleading.

Effective Date Requested - For 2026 plans, the implementation date should be 1/1/26.

Requested Filing Mode - All form filings are considered "File & Use."

Market Type - Select "Individual" OR "Group" – Individual and group filings must be submitted separately.

Group Market Size – If it is group coverage, select "Small" – Small and large group filings cannot be combined.

Filing Description - A detailed description must be provided and should include (if applicable) an explanation of any plan name changes and/or form number changes for 2025 plans that will be offered in 2026. This section should serve as the "cover letter" for the submission.

FORM SCHEDULE TAB

Lead Form Number - Once the filing has been submitted, this field cannot be edited; please ensure that it is completed correctly prior to submission.

Form Name

1. Any 2025 plan year forms that are being re-submitted **without revisions** for the 2026 plan year should maintain the same form name (the year can be updated as necessary).

2. Any requests to alter form names should be cleared with the Division prior to filing and explained in detail in the form filing (in the Filing Description field on the General Information tab).

Form Number

1. Any 2025 plan form numbers that are being re-submitted **without revisions** for the 2026 plan year should maintain the same form number, although carriers can change the year designation from 2025 to 2026, if this information is included as part of the form number.

2. Any requests to alter form numbers outside of the allowed adjustment for plan year should be cleared with the Division prior to filing and explained in detail in the form filing (in the Filing Description field on the General Information tab).

Form Type - Select appropriate form type.

Action - Select appropriate action.

Readability Score - Readability scores are required in Colorado – PLEASE SEE §10-16-107.3, C.R.S.

Attachments – the following documents must be attached:

1. All forms that will apply, and be available, to the policyholder for the 2026 plan year.

2. Clean copies of form documents that were filed for 2025 plans and HAVE NOT been revised must still be attached under the Form Schedule tab. These documents will be reviewed by the Division in their entirety, and objections will be written on any previously unidentified errors/omissions.

EVIDENCE OF COVERAGE

Evidence of Coverage (EOC) documents must be submitted under the Form Schedule Tab in the Form Filing (Non-binder) in SERFF. For plans offered through C4HCO, EOC documents must also be attached under the Supporting Documentation tab of the binder (see below). EOCs submitted in the Form Filing for the 2026 plan year should be submitted at the "Master" level with full variability. A separate "master" level EOC must be submitted for **Colorado Option Standardized Plans**. EOCs should be prepared at the product level, or for different major variations such as **Colorado Option Standardized Plan**, HSA-eligible, specific metal levels, or on- or off-exchange.

Formatting:

- Policy forms, including EOCs, must follow the standardized format for section names and placement of section names outlined in §10-16-137 C.R.S. and Colorado Amended Insurance Regulation 4-2-34.

- EOCs must include all essential health benefits described in Colorado Insurance Regulation 4-2- 42.

- Policy forms, including EOCs, specific to the **Colorado Option Standardized Plans** must include requirements specified in Colorado Insurance Regulation 4-2-81. Specific items include, but are not limited to:
    - Prenatal and postnatal visits in accordance with Regulation 4-2-81;
    - Tobacco cessation programs, including Colorado Quitline;
    - A listing of diabetic supplies that are covered at $0 cost-sharing and not subject to a deductible, including at least one brand or form of continuous glucose monitor; and
    - Outpatient education for prediabetes through CDC-recognized programs.

- EOCs are subject to the readability requirements outlined in §10-16-107.3, C.R.S., and the Meaningful Access requirements listed above. The addendum with language taglines in the top 15 languages spoken by the LEP populations of Colorado must be attached to the EOCs.

Variable Language:

- For EOCs submitted through the form filing, carriers must use variable language for each document submitted. A Statement of Variability MUST accompany any bracketed or variable

language. For the purposes of form certification, the Division does not consider the Statement of Variability to be a policy form, per se, but it is still a required filing element and MUST be submitted on the Supporting Documentation tab as part of the form filing. Cost-sharing arrangements – including copayment, coinsurance, deductible, and maximum out-of-pocket amounts – should be bracketed, and the variable options presented should include the entire possible range of minimum and maximum amounts for all variations (as defined in Colorado Insurance Regulations 4-2-42 and 4-2-81). Variant-specific plan filings in the binder will contain the specific cost-sharing.

- Bracketed language must be complete, and the variable options must be identified in the Statement of Variability.

Carriers submitting revised EOC documents must submit a redlined version showing all changes that were made. In the initial submission, the redlines must show the changes made from the approved 2024 plan year documents. Redline documents showing changes made in response to objections must be submitted with objection responses. Redlined copies are submitted under the Supporting Documentation tab.

Carriers offering plans through C4HCO must submit in the binder an EOC form for every plan being offered. For the 2026 plan year, this will include **every cost-sharing plan variation of every on-exchange individual plan, and every Colorado Option Standardized Plan and cost-sharing variation, both on-exchange and off-exchange**. Detailed instructions regarding the specific plans and plan naming is provided in the Binder instructions. All EOCs will be required in English and Spanish for all on-exchange **individual** plans, and for all individual and small group **Colorado Option Standardized Plans**, both on-exchange and off-exchange. The EOC forms for C4HCO will be submitted through the Plan Variant Level EOCs and SBCs binder submission in SERFF, and at a date after reviews are completed, specified by the Division.

PLEASE REFER TO THE "COLORADO's ACA BINDER FILING INSTRUCTIONS FOR 2026" (when they become available) FOR DETAILED EOC INSTRUCTIONS AND BINDER SUBMISSION REQUIREMENTS.

SUMMARY OF BENEFITS AND COVERAGE AND COLORADO SUPPLEMENT TO THE SBC

Summary of Benefits and Coverage (SBC) and Colorado Supplement to the Summary of Benefits and Coverage (COSSBC) documents must be submitted under the Form Schedule Tab in the Form Filing (Non-binder) in SERFF. For plans offered through C4HCO, SBC documents must also be attached under the Supporting Documentation tab of the binder. SBCs and COSSBCs submitted in the Form Filing for the 2026 plan year should be submitted at the "Master" level with full variability. Separate "master" level SBCs and COSSBCs must be submitted for **Colorado Option Standardized Plans**.

Instructions for preparation and submittal of SBC and COSSBC documents are being provided in a separate Instructions 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 Instructions for 2026.

UNIFORM APPLICATION

The Uniform Application must be submitted under the Form Schedule Tab section of SERFF.

Per §10-16-107.5 C.R.S. and Amended Colorado Insurance Regulation 4-2-45, effective January 1, 2025, all carriers offering individual and small group health benefit plans ***inside*** and ***outside*** of C4HCO must use the individual and small group Uniform Applications developed by the Division, which are attached as Appendix A and B of Amended Colorado Insurance Regulation 4-2-45. Carriers may not alter, modify, or change the uniform applications developed by the Division. Carriers may not add logos or other graphics or text to the uniform applications except where designated on the uniform applications found in Appendix A and Appendix B of Colorado Insurance Regulation 4-2-45.

**NOTE: Carriers offering stand-alone pediatric dental plans are NOT required to use the Uniform Application.

GROUP/EMPLOYER, SUPPLEMENTAL AND ONLINE APPLICATIONS

Carriers of Small Group products shall also provide a copy of the application used to enroll groups or employers. Carriers will be allowed to submit a supplemental application to be used in conjunction with the Uniform Application. Supplemental individual applications should **only be used to collect information that a carrier needs to be able to successfully enroll an individual into their IT system** (i.e., to gather a required data field for a member database). Lengthy applications containing excessive questions are not allowed. Any supplemental applications that exceed more than 3-5 pages will be questioned, and carriers will be required to provide an adequate justification of the additional information needed. If the carrier offers other insurance products (i.e., disability insurance, life insurance, etc.), these offerings must not be made on the same supplemental application being used in conjunction with the Uniform Application. Such products frequently require the gathering of personal health information that is not appropriate in conjunction with application for ACA health benefit plans.

Since the Division has not produced an electronic version of the Uniform Application, carriers are allowed to create and submit an "online" version of this form. ONLY MINOR MODIFICATIONS to the Uniform Application will be allowed (i.e., changes to address technical issues or requirements).

Carriers submitting revised supplemental application documents must submit a redlined version showing all changes that were made. In the initial submission, the redlines must show the change made from the approved 2025 plan year documents. Redline documents showing changes made in response to objections must be submitted with objection responses. Redlined copies are submitted under the Supporting Documentation tab.

POLICY FORMS

All policy forms, including those for the **Colorado Option Standardized Plans** must be listed under the Form Schedule Tab, and copies of the actual documents must be attached.

****NOTE: In Colorado, ACA health benefit plans are not allowed to use riders. Riders for EHBs – i.e., prescription drugs – are NOT permitted; all EHBs must be incorporated into the policy documents as covered benefits.**

Formatting:

Policy forms must follow the standardized format for section names and placement of section names outlined in §10-16-137 C.R.S. and Colorado Amended Insurance Regulation 4-2-34. Failure to follow these requirements will result in an immediate objection and may delay the review of the filing.

Variable Language:

- Carriers should submit one base document accompanied by a Statement of Variability for that form.
- Cost-sharing arrangements – including copayment, coinsurance, deductible, and maximum out- of-pocket amounts – must be bracketed, and the variable options presented should include the entire possible range of minimum and maximum amounts (i.e. [30% to 100%] or [$10 to $50]) for the proposed metal-level plans, as defined in Colorado Insurance Regulations 4-2-42 and 4- 2-81. Plan filings in the binder will contain the specific cost-sharing structures.

Bracketed language must be complete, and options must be identified in a statement of variability.

Carriers submitting revised policy form documents must submit a redlined version showing all changes that were made. In the initial submission, the redlines must show the changes made from the approved 2025 plan year documents. Redline documents showing changes made in response to objections must be submitted with objection responses. Redlined copies are submitted under the Supporting Documentation tab.

** PLEASE NOTE: The following documents are not considered forms, and should NOT be filed with the Division:

1) Billing Change Form;
2) Employer Reimbursement Form;
3) Employee Dependent Waiver;
4) Employee Disenrollment Form;
5) Affidavit of Common Law Marriage;
6) Request for Enrollment of Common Law Spouse;
7) EFT (electronic checks, credit/debit card) authorization form; and
8) Any additional purely administrative forms.

If these documents are contained in a filing, an objection will be written asking for their removal, which will delay the review process.

SUPPORTING DOCUMENTATION TAB

Detailed instructions regarding certificates of compliance are provided in Colorado Insurance Regulation 4-2-41. The following documents are required:

1. Certification of Compliance
2. Statement of Variability
3. Letter of Authority (if applicable)
4. Specific Coverages list - To assist with forms review, the Division has added a document to

the SERFF Supporting Documents tab for ACA Form Filings. *On the Specific Coverages and/or Exclusions List, please provide the appropriate section and page number(s) where the coverages listed are explained in the EOCs or COCs. The list also includes coverages specific to the **Colorado Option Standardized Plans**. Please provide this information on any other specific benefits that are added after these forms instructions were issued.*

5. Redlined copies of 2025 forms that are being refiled, with revisions - *Carriers submitting revised documents for the 2026 plan year must submit a redlined version showing all changes that were made. In the initial submission, the redlines must show the changes made from the approved 2025 plan year documents. Redline documents showing changes made in response to objections must be submitted with objection responses. Redlined copies are submitted under the Supporting Documentation tab.*

COMPANIES AND CONTACT TAB

Filing contact and company information should be up to date

APPENDIX A - GENDER DYSPHORIA SERVICE COVERAGE TEMPLATE

GENRE and SURGICAL PROCEDURE
General
Laser or electrolysis hair removal
Breast/ Chest Surgery (Male to Female)
Augmentation Mammoplasty
Implants/Lipofillings
Breast/chest augmentation, reduction, construction
Genital Surgery (Male to Female)
Penectomy
Orchiectomy
Vaginoplasty
Dilator (Medical Equipment)
Clitoroplasty
Vulvoplasty
Labiaplasty
Prostatectomy
Urethroplasty
Vagina/Perineum reconstruction
Non-Breast/Chest Surgical Interventions (Male to Female)
Facial Feminization Surgery
Blepharoplasty (eye and lid modification)
Face/forehead and/or neck tightening
Facial bone remodeling for facial feminization

Genioplasty (chin width reduction)
Rhytidectomy (cheek, chin, and neck)
Cheek, chin, and nose implants
Lip lift/augmentation
Mandibular angle augmentation/creation/reduction (jaw)
Orbital recontouring
Liposuction
Lipofilling
Voice Surgery
Thyroid Cartilage Reduction/Reduction thyrochondroplasty
Gluteal Augmentation (Implants/Lipofilling)
Hair Reconstruction
Rhinoplasty (nose reshaping)
Breast/Chest Surgery (Female to Male)
Subcutaneous Mastectomy (for Creation of Male Chest)
Salpingectomy
Metoidioplasty
Phalloplasty
Vaginectomy
Vulvectomy
Scrotoplasty
Urethroplasty
Trachelectomy

Penis/perineum reconstruction
Implantation of Erection and/or Testicular Prosthesis
Non-Genital, Non-Breast/Chest Surgical Interventions (Female to Male)
Voice Surgery
Liposuction
Lipofilling
Pectoral Implants
Calf Implants
Nipple reconstruction following mastectomy
Voice Therapy Lessons
Simple/Total Mastectomy
Partial Mastectomy
Modified Radical Mastectomy
Radical Mastectomy
Breast reduction (reduction mammoplasty)
Breast/chest augmentation, reduction, construction
Genital Surgery (Female to Male)
Hysterectomy
Ovariectomy/Oophorectomy