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18.01.70 - RULE TO IMPLEMENT THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT PLAN DESIGN

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000. LEGAL AUTHORITY.
This Rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapters 2 and 47, Idaho Code. (1-25-95)

001. TITLE AND SCOPE.

01. Title. These rules shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18, Title 01, Chapter 70, "Rules Governing Small Employer Health Insurance Availability Act Plan Design." (1-25-95)

02. Scope. The Act and this Rule are intended to promote broader spreading of risk in the small employer marketplace. The Act and Rule are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this Rule. (1-25-95)

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(16)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (1-25-95)

003. ADMINISTRATIVE APPEALS.
All contested cases shall be governed by the provisions of IDAPA 04.11.01, Idaho Rules of Administrative Procedure of the Office of the Attorney General. (1-25-95)

004. DEFINITIONS.
As used in this Rule: (1-25-95)

01. Benefit Percentage. Benefit percentage is the percentage of the cost of a health care service paid by the insurer under a health insurance plan as defined in the schedule of benefits. (1-25-95)

02. Calendar Year. Calendar year is a period of one (1) year which starts on January 1st and ends on December 31st. (1-25-95)

03. Coinsurance. Coinsurance is a percentage of the cost of a health care service, paid by the patient under a health insurance plan, as defined in the schedule of benefits. (1-25-95)

04. Copayment. Copayment is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a copayment will be required are specified in the schedule of benefits. (1-25-95)

05. Expense. Expense means the expense incurred for a covered service or supply. A physician or other licensed practitioner has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: (1-25-95)

a. For a service or supply which is not medically necessary; or (1-25-95)

b. Which is in excess of reasonable and customary charge for a service or supply. (1-25-95)

06. Medical Emergency. Medical emergency means a severe onset of a condition which: (1-25-95)

a. Results in symptoms which occur suddenly and unexpectedly; and (1-25-95)

b. Requires immediate physician's care to prevent death or serious impairment of the insured person's health; or (1-25-95)

c. Poses a serious threat to the patient or to others. (1-25-95)

07. Medically Necessary Service or Supply. Medically necessary service or supply means one which is ordered by a physician and which the small employer carrier or a qualified party or entity selected by us determines is: (1-25-95)

a. Provided for the diagnosis or direct treatment of an injury or sickness; (1-25-95)

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (1-25-95)

c. Is not considered experimental or investigative; (1-25-95)

d. Provided in accord with generally accepted medical practice; (1-25-95)

e. The most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, in-patient vs. out-patient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.) The fact that the insured person's physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (1-25-95)

08. Out-of-pocket Expense. Out-of-pocket expense is the medical expense that an insured must pay, which includes deductibles and coinsurance but not copayment, as defined in the schedule of benefits. (1-25-95)

09. Physician. Physician means any of the following licensees duly licensed by the state of Idaho to practice in any of the following categories of health care professions; (1-25-95)

a. Chiropractor; (1-25-95)

b. Dentist; (1-25-95)

c. Optometrist; (1-25-95)

d. Pharmacist; (1-25-95)

e. Physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; and (1-25-95)

f. Podiatrist; and (1-25-95)

g. Any other licensed practitioner who is acting within the scope of that license and who performs a service which is payable under the policy when performed by any of the above health care practitioners. A physician does not include a person who lives with the insured or is part of insureds family (spouse, child, brother, sister, or parent of insured or insureds spouse). (1-25-95)

10. Pre-Existing Condition. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition. (1-25-95)

a. A health benefit plan shall not define a pre-existing condition more restrictively than: (1-25-95)

i. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (1-25-95)

ii. A condition for which medical advice, diagnosis, care or treatment was recommended or received

during the six (6) months immediately preceding the effective date of coverage; or (1-25-95)

iii. A pregnancy existing on the effective date of coverage. (1-25-95)

b. A health benefit plan shall waive any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than thirty (30) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan. (1-25-95)

c. A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan. (1-25-95)

11. Restricted Network Provision. Restricted network provision means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Chapter 34, Title 41, Idaho Code, Hospital and Professional Service Corporations, and Chapter 39, Title 41, Idaho Code, Health Maintenance Organizations, to provide health care services to covered individuals. (1-25-95)

005. -- 014. (RESERVED).

015. COORDINATION OF BENEFITS.
Coordination of benefits shall be utilized on the small employer basic and standard plan based upon the current NAIC birthday rule so long as such Coordination of Benefits would not be in conflict with Chapter 22, Title 41, Idaho Code. This provision will expire upon final adoption of the NAIC Coordination of Benefits model rule or upon order Director. (1-25-95)

016. LIMITATIONS AND EXCLUSIONS.

01. Services Not Medically Necessary, Excluded. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (1-25-95)

02. No Coverage. Custodial, convalescent or intermediate level care or rest cures. (1-25-95)

03. Experimental or Investigational. Services which are experimental or investigational. (1-25-95)

04. Workers' Compensation, Medicare, Champus. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (1-25-95)

05. No Charges. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (1-25-95)

06. No Medical Diagnosis. Services (including surgery), self-help and training programs for weight control, nutrition, smoking cessation, etc., as well as prescription drugs used in conjunction with such programs and services. (1-25-95)

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment for non-congenital injury or surgery. Mastectomy reconstruction is covered if within two (2) years of mastectomy. (1-25-95)

08. Artificial Insemination, Infertility, Sexual Dysfunction. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (1-25-95)

09. Induced Infertility. Services for reversal of elective, surgically or pharmaceutically induced infertility. (1-25-95)

10. Vision. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12). (1-25-95)

11. Limitation Foot Care. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatmental of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (1-25-95)

12. Spinal Manipulation. Chiropractic services will be subject to one thousand dollar ($1,000) per year limit, subject to the policy deductible and co-insurance. (1-25-95)

13. Dental, Orthodontic Services. Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). (1-25-95)

14. Hearing Tests. Hearing tests without illness being suspect. (1-25-95)

15. Hearing Aids, Supplies. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (1-25-95)

16. Speech Tests. Speech tests and therapy except as specifically allowed in the policy for children under the age of twelve (12). (1-25-95)

17. Private Room Accommodation Charges. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (1-25-95)

18. Services Performed by a Member of the Insureds Family. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (1-25-95)

19. No Coverage Prior to Effective Date of Coverage. Care incurred before the effective date of the person's coverage. (1-25-95)

20. Covered Injury or Disease. Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (1-25-95)

21. Act of War or Armed Conflict. Injury or sickness caused by war or armed international conflict. (1-25-95)

22. Operation and Treatment, Sexual Change. Sex change operations and treatment in connection with transsexualism. (1-25-95)

23. Counseling. Marriage and family and child counseling except as specifically allowed in the policy. (1-25-95)

24. Acupuncture. Acupuncture except when used as anesthesia during a covered surgical procedure. (1-25-95)

25. Private Duty Nursing. Private duty nursing except as specifically allowed in the policy. (1-25-95)

26. Employer Maintained Medical or Dental Care. Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (1-25-95)

27. Termination. Incurred after the date of termination of the insured's coverage, except as allowed by any extension of benefits provision in the policy. (1-25-95)

28. Personal Convenience Items. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (1-25-95)

29. Failure to Keep a Scheduled Visit. Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (1-25-95)

30. Screening Examinations. Charges for screening examinations except as otherwise provided in the policy. (1-25-95)

31. No Allowance. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (1-25-95)

32. Pre-existing Conditions. Pre-existing conditions, except as provided specifically in the policy. (1-25-95)

017. -- 999. (RESERVED).

APPENDIX A
HMO STANDARD BENEFIT PLAN

Schedule of Benefits
All Benefit Areas

Calendar Year Benefit Maximum	$100,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	$15
-Children	$0
Benefit Percentage	$100%
Coinsurance Percentage.	$0%
Annual Benefit Maximum*	$500
Vision Annual Benefit Sub-cap*	$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	$15
Benefit Percentage	100%
Coinsurance Percentage	0%
Other Maternity (Benefit Area B2)	
Copayment (per admission)	$500
Benefit Percentage	80%
Coinsurance Percentage	20%
Inpatient Services (Benefit Area C)	
Copayment (per admission)	$500
Benefit Percentage	80%

Coinsurance Percentage	20%
Outpatient Services (Benefit Area D)	
Copayment	
1. Emergency Room+	$100
2. Outpatient Surgery	$200
3. Office Visits and Other Outpatient Services	$20
+$100 network provider; $200 non-designated provider	
Transportation & Medical Equipment (Benefit Area E)	
Emergency Ambulance Service	
Annual Benefit Maximum*	$750
Copayment	$100
Benefit Percentage	-0-
Coinsurance Percentage	-0-
Durable Medical Equipment Annual Benefit Maximum*	$15,000
Copayment	-0-
Benefit Percentage	80%
Coinsurance Percentage	20%
Psychiatric and Substance Abuse (Benefit Area F)	
Annual Benefit Maximum (Inpatient and Outpatient)*	$5,000
Outpatient	
Sub-cap	1,500
Copayment	-0-
Benefit percentage	50%
Coinsurance percentage	50%
Inpatient	
Copayment	500
Benefit percentage	80%
Coinsurance percentage	20%
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	$5,000
Family	$10,000

(Applicable to Benefit Areas "B2", "C", "D", "E" and "F")

*Maximum benefit payable during any twelve (12) month period.

** One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX B
STANDARD BENEFIT PLAN

Schedule of Benefits

All Benefit Areas	
Calendar Year Benefit Maximum	$100,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	$15
-Children	-0-
Benefit Percentage.	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	$500
Vision Annual Benefit Sub-cap*	$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment.	$15
Benefit Percentage	100%
Coinsurance Percentage	0%
Benefit Areas B2, C, D, E, F	
Calendar Year Deductible	
-Individual	$500
-Family	$1,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Out-of-Pocket Expense Limit	
-Individual	$5,000
-Family	$10,000
Emergency Ambulance Service Annual Benefit Maximum*	$750
Durable Medical Equipment Annual Benefit Maximum*	$15,000

Psychiatric and Substance Abuse Services	
Annual benefit Maximum*	$5,000
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	$10
Benefit Percentage	100%**
Coinsurance	0%**

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX C
HMO BASIC BENEFIT PLAN

Schedule of Benefits

All Benefit Areas	
Calendar Year Benefit Maximum	$25,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	$15
-Children	-0-
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	$500
Vision Annual Benefit Sub-cap*	$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	$15
Benefit Percentage	100%
Coinsurance Percentage.	0%
Other Maternity (Benefit Area B2)	
Copayment (per admission)	$1,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Inpatient Services (Benefit Area C)	
Copayment (per admission)	$1,000

Benefit Percentage	50%
Coinsurance Percentage	50%
Outpatient Services (Benefit Area D)	
Copayment	
1. Emergency Room+	$100
2. Outpatient Surgery	$400
3. Office Visits and Other Outpatient Services	$30
+$100 network provider; $200 non-designated provider	
Transportation & Medical Equipment (Benefit Area E)	
Emergency Ambulance Service	
Annual Benefit Maximum*	$750
Copayment	$200
Benefit Percentage	100%
Coinsurance Percentage	-0-
Durable Medical Equipment	
Annual Benefit Maximum*	$15,000
Copayment	-0-
Benefit Percentage	50%
Coinsurance Percentage	50%
Psychiatric and Substance Abuse (Benefit Area F)	
Annual Benefit Maximum (Outpatient)*	$1,500
Copayment	-0-
Benefit percentage	50%
Coinsurance percentage	50%
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	$5,000
Family	$10,000

(Applicable to Benefit Areas "B2", "C", "D", "E")

*Maximum benefit payable during any twelve (12) month period.
**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured

must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX D
BASIC BENEFIT PLAN

Schedule of Benefits

All Benefit Areas	
Calendar Year Benefit Maximum	$25,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	$15
-Children under Age 12	-0-
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	$500
Vision Annual Benefit Sub-cap*	$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	$15
Benefit Percentage	100%
Coinsurance Percentage	0%
Benefit Areas B2, C, D, E, F	
Calendar Year Deductible	
- Individual	$1,000
- Family	$2,000
Benefit Percentage.	50%
Coinsurance Percentage	50%
Out-of-Pocket Expense Limit	
- Individual	$5,000
- Family	$10,000
Emergency Ambulance Service Annual Benefit Maximum*	$750
Durable Medical Equipment Annual Benefit Maximum*	$15,000
Psychiatric and Substance Abuse Services Annual Benefit Maximum*	
Outpatient	$2,500
Pharmacy Benefits (Benefit Area G)	

Copayment per Prescription	$10
Benefit Percentage	100%**
Coinsurance	0%**

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.