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IDAPA 18
TITLE 01
Chapter 73

18.01.73 - RULE TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT PLAN DESIGN

000. LEGAL AUTHORITY.
This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapters 2, 52, and 55, Title 41, Idaho Code. (1-1-01)T

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.73, "Rule to Implement the Individual Health Insurance Availability Act Plan Design". (6-30-95)

02. Scope. The Act and this Rule are intended to promote broader spreading of risk in the individual marketplace. The Act and Rule are intended to regulate all health benefit plans sold to eligible individuals. Carriers that provide health benefit plans to eligible individuals are intended to be subject to all of the provisions of the Act and this Rule. (6-30-95)

002. WRITTEN INTERPRETATIONS.
In accordance with section 67-5201(19)(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. (7-1-98)

003. ADMINISTRATIVE APPEALS.
All contested cases shall be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". (1-1-01)T

004. DEFINITIONS.
For the purposes of this Rule, the following terms will be used as defined below: (6-30-95)

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. (6-30-95)

02. Calendar Year. Calendar year is a period of one (1) year which starts on January 1st and ends on December 31st. (6-30-95)

03. Coinsurance. Coinsurance is a percentage of the cost of a health care service, paid by the insured under a health insurance plan, as defined in the schedule of benefits. (1-1-01)T

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. The Copayments must be paid before any other payment will be made under the policy. The copayment will not count toward any deductible or out-of-pocket expense required under the policy. (1-1-01)T

05. Deductible. Deductible means the amount of the covered charge each insured is obligated to pay each calendar year before the plan will pay for covered medical services. All covered charges are subject to the Deductible amount unless specifically noted otherwise. (1-1-01)T

06. Out-Of-Pocket Expense. Out-of-pocket expense is the medical expense that an insured is obligated to pay, which includes coinsurance as defined in the schedule of benefits. The out-of-pocket expense does not include deductibles, copayments, pharmacy expenses, and expenses for non-covered services and supplies. After the out-of-pocket expense has been reached, services will be provided at one hundred percent (100%) except for specific deductibles, copayments, pharmacy benefits, non-covered services and supplies. (1-1-01)T

07. Pre-Existing Condition. Pre-existing condition is defined in Section 41-5208(3), Idaho Code. (6-30-95)

08. Provider. Provider means any of the following licensees duly licensed to practice in any of the following categories of health care professions: (1-1-01)T

a. Licensed general hospital; (1-1-01)T

b. Chiropractor; (6-30-95)

c. Dentist; (6-30-95)

d. Optometrist; (6-30-95)

e. Pharmacist; (6-30-95)

f. Physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; (6-30-95)

g. Podiatrist; and (6-30-95)

h. Any other licensed facility or 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 providers. (1-1-01)T

i. A provider does not include a person who lives with the insured or is part of the insured's family (insured, insured's spouse, or a child, brother, sister, or parent of insured or insured's spouse). (1-1-01)T

09. Eligible Expense. Eligible expense means the expense incurred for a covered service or supply. A physician or other licensed facility or provider 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: (1-1-01)T

a. For a service or supply which is not medically necessary; (1-1-01)T

b. Which is in excess of reasonable and customary charge for a service or supply; (1-1-01)T

c. Which is in excess of any contractual arrangements; (1-1-01)T

d. For any services or supplies which an Insured would have no legal obligation to pay in the absence of coverage under this policy or any similar coverage; or (1-1-01)T

e. For which no charge or a different charge is usually made in the absence of insurance coverage. (1-1-01)T

10. Medically Necessary Service Or Supply. Medically necessary service or supply means one which is ordered by a provider and which the Carrier's medical staff or qualified party or entity determines is: (1-1-01)T

a. Provided for the diagnosis or direct treatment of an injury or sickness; (6-30-95)

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (6-30-95)

c. Is not considered experimental or investigative; (6-30-95)

d. Provided in accord with generally accepted medical practice; (6-30-95)

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); (6-30-95)

f. The fact that the insured's provider prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (1-1-01)T

11. Emergency Services. Emergency services means those health care services that are provided in a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in: (1-1-01)T

a. Placing the Insured's health in serious jeopardy; (1-1-01)T

b. Serious impairment to bodily functions; or (1-1-01)T

c. Serious dysfunction of any bodily organ or part. (1-1-01)T

005. -- 009. (RESERVED).

010. COORDINATION OF BENEFITS.
Coordination of Benefits shall be utilized on the Individual basic, standard, and catastrophic A and catastrophic B plans based upon IDAPA 18.01.74, "Coordination of Benefits". (1-1-01)T

011. LIMITATIONS AND EXCLUSIONS.

01. Not Medically Necessary. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (6-30-95)

02. Custodial, Convalescent, Intermediate. Custodial, convalescent or intermediate level care or rest cures. (6-30-95)

03. Experimental, Investigational. Services which are experimental or investigational. (6-30-95)

04. Workers Compensation, Medicare Or CHAMPUS. Services covered by Workers' Compensation, Medicare or CHAMPUS. (1-1-01)T

05. No Charges, No Legal Obligation To Pay. 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. (6-30-95)

06. No Medical Diagnosis. Services for weight control, nutrition, and smoking cessation, including self-help and training programs, as well as prescription drugs used in conjunction with such programs and services. (7-1-98)

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment or surgery for congenital anomalies. Mastectomy reconstruction is covered as described in the Women's Health and Cancer Rights Act. (1-1-01)T

08. Artificial Insemination And Infertility Treatment. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (6-30-95)

09. Reversal Of Elective Infertility. Services for reversal of elective, surgically or pharmaceutically induced infertility. (1-1-01)T

10. Vision Therapy. 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. (6-30-95)

11. Weak, Strained, Or Flat Feet. For treatment of weak, strained, or flat feet, including orthopedic shoes, orthotic devices, or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (1-1-01)T

12. Manipulative Therapy And Related Treatment. Manipulative therapy, including heat treatments and ultrasound, of the musculoskeletal structure and other fractures and dislocations of the extremities will be subject to the rehabilitation therapy limit described in the Schedule of Benefits. (1-1-01)T

13. Dental, Tempormandibular Joint (TMJ) And Orthodontic Services. Dental and orthodontic services, except those needed for treatment of an accidental injury to sound natural teeth incurred while covered by the plan and limited to six (6) months from the date of injury. (1-1-01)T

14. Hearing Tests And Hearing Aids. Hearing tests without illness being indicated. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (1-1-01)T

15. Private Room. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (6-30-95)

16. Prior To Effective Date. Care incurred before the effective date of the person's coverage. (6-30-95)

17. Immunizations And Medical Exams And Tests. 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. (6-30-95)

18. Injury Or Sickness. Injury or sickness caused by war or armed international conflict or incurred as a result of voluntary participation in an assault, felony, insurrection or riot. (1-1-01)T

19. Sex Change Operations. Sex change operations and treatment in connection with transsexualism. (6-30-95)

20. Marriage and Family Counseling. Marriage and family counseling except as specifically allowed in the policy. (1-1-01)T

21. Acupuncture. Acupuncture, except when used as pain management by a licensed provider. (1-1-01)T

22. Private Duty Nursing. Private duty nursing except as specifically allowed in the policy. (6-30-95)

23. Medical Services Received From Employer, Labor Union Association. 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. (6-30-95)

24. Termination. Services incurred after the date of termination of a covered person's coverage. (1-1-01)T

25. Personal Hygiene And Convenience Items. Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (6-30-95)

26. 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. (6-30-95)

27. Screening Examinations. Charges for screening examinations except as otherwise provided in the policy. (6-30-95)

28. Wigs Or Hair Loss. Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness.

(6-30-95)

29. Pre-Existing Conditions. Pre-existing conditions, except as provided specifically in the policy. (6-30-95)

30. Obesity. Medical or surgical procedures primarily for treatment of obesity or for reversal, revision, or complications thereof. (1-1-01)T

012. BENEFITS.
Based on the provisions of Section 41-5511, Idaho Code, the Guaranteed Issue Schedule of Benefits Attachments for Basic Benefit Plan, Standard Benefit Plan, Catastrophic "A" Benefit Plan, and Catastrophic "B" Benefit Plan have been replaced by the new Idaho Individual High-Risk Plan Designs, as follows: (1-1-01)T

BASIC BENEFIT PLAN	
Schedule of Benefits	
All Benefit Areas - Lifetime Benefit Maximum per Carrier	$500,000
Preventive Services - **Benefit Area "A"** (annual benefit maximum) Subject to Deductible nd Coinsurance Mammography benefits are not limited to the preventive services benefit	$200
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	$500
Benefit Percentage	50%
Coinsurance Percentage	50%
Individual (Out-of-Pocket Expense Maximum not including Deductible or Co-Payments)	$20,000
Normal Maternity Benefit Deductible - **Benefit Area "B"** Not applicable to involuntary complications of pregnancy	$5,000
Organ Transplant - **Benefit Area "C"** (lifetime maximum benefit)	$150,000
Skilled Nursing Facility - **Benefit Area** "**C**" (annual benefit maximum)	45 days
Rehabilitation Therapy - **Benefit Area** "**C**" (annual inpatient benefit maximum)	$25,000
Rehabilitation Therapy - **Benefit Area "D"** (combined annual outpatient benefit max)	$2,000
Home Health Care Benefits - **Benefit Area "D"** (annual benefit maximum)	$5,000
Hospice Care - **Benefit Area "D"** (annual benefit maximum)	$5,000
Ambulance Service - **Benefit Area "E"** (annual benefit maximum)	$2,000
Durable Medical Equipment - **Benefit Area "E"** (annual benefit maximum)	$10,000
Psychiatric and Substance Abuse Services - **Benefit Area "F"** Covered benefit as an inpatient or outpatient combined (annual benefit maximum)	$5,000

BASIC BENEFIT PLAN	
Pharmacy - **Benefit Area "G"**	
Calendar Year Pharmaceutical Deductible - Individual	$250
Benefit Percentage	50%
Coinsurance Percentage Does not apply to Out-of-Pocket Expense limit	50%

(1-1-01)T

STANDARD BENEFIT PLAN	
Schedule of Benefits	
All Benefit Areas - Lifetime Benefit Maximum per Carrier	$l,000,000
Preventive Services - **Benefit Area "A"** (annual benefit maximum) Subject to Deductible and Coinsurance Mammography benefits are not limited to the preventive services benefit	$200
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	$1,000
Benefit Percentage	70%
Coinsurance Percentage	30%
Individual (Out-of-Pocket Expense Maximum not including Deductible or Co-Payments)	$10,000
Normal Maternity Benefit Deductible - **Benefit Area "B"** Not applicable to involuntary complications of pregnancy	$5,000
Organ Transplant - **Benefit Area "C"** (lifetime maximum benefit)	$150,000
Skilled Nursing Facility - **Benefit Area** "**C**" (annual benefit maximum)	45 days
Rehabilitation Therapy - **Benefit Area** "**C**" (annual inpatient benefit maximum)	$25,000
Rehabilitation Therapy - **Benefit Area "D"** (combined annual outpatient benefit max)	$2,000
Home Health Care Benefits - **Benefit Area "D"** (annual benefit maximum)	$5,000
Hospice Care - **Benefit Area "D"** (annual benefit maximum)	$5,000
Ambulance Service - **Benefit Area "E"** (annual benefit maximum)	$2,000
Durable Medical Equipment - **Benefit Area "E"** (annual benefit maximum)	$10,000
Psychiatric and Substance Abuse Services - **Benefit Area "F"** Covered benefit as an inpatient or outpatient combined (annual benefit maximum)	$5,000

STANDARD BENEFIT PLAN	
Pharmacy - **Benefit Area "G"**	
Calendar Year Pharmaceutical Deductible - Individual	$250
Benefit Percentage	50%
Coinsurance Percentage Does not apply to Out-of-Pocket Expense limit	50%

(1-1-01)T

CATASTROPHIC "A" BENEFIT PLAN	
Schedule of Benefits	
All Benefit Areas - Lifetime Benefit Maximum per Carrier	$1,000,000
Preventive Services - **Benefit Area "A"** (annual benefit maximum) Subject to Deductible and Coinsurance Mammography benefits are not limited to the preventive services benefit	$200
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	$2,000
Benefit Percentage	70%
Coinsurance Percentage	30%
Individual (Out-of-Pocket Expense Maximum not including Deductible or Co-Payments)	$10,000
Normal Maternity Benefit Deductible - **Benefit Area "B"** Not applicable to involuntary complications of pregnancy	$5,000
Organ Transplant - **Benefit Area "C"** (lifetime maximum benefit)	$150,000
Skilled Nursing Facility - **Benefit Area "C"** (annual benefit maximum)	45 days
Rehabilitation Therapy - **Benefit Area "C"** (annual inpatient benefit maximum)	$25,000
Rehabilitation Therapy - **Benefit Area "D"** (combined annual outpatient benefit max)	$2,000
Home Health Care Benefits - **Benefit Area "D"** (annual benefit maximum)	$5,000
Hospice Care - **Benefit Area "D"** (annual benefit maximum)	$5,000
Ambulance Service - **Benefit Area "E"** (annual benefit maximum)	$2,000
Durable Medical Equipment - **Benefit Area "E"** (annual benefit maximum)	$10,000
Psychiatric and Substance Abuse Services - **Benefit Area "F"** Covered benefit as an inpatient or outpatient combined (annual benefit maximum)	$5,000

CATASTROPHIC "A" BENEFIT PLAN	
Pharmacy - **Benefit Area "G"**	
Calendar Year Pharmaceutical Deductible - Individual	$500
Benefit Percentage	50%
Coinsurance Percentage Does not apply to Out-of-Pocket Expense limit	50%

(1-1-01)T

CATASTROPHIC "B" BENEFIT PLAN	
Schedule of Benefits	
All Benefit Areas - Lifetime Benefit Maximum per Carrier	$1,000,000
Preventive Services - **Benefit Area "A"** (annual benefit maximum) Subject to Deductible and Coinsurance Mammography benefits are not limited to the preventive services benefit	$200
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	$5,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Individual (Out-of-Pocket Expense Maximum not including Deductible or Co-Payments)	$10,000
Normal Maternity Benefit Deductible - **Benefit Area "B"** Not applicable to involuntary complications of pregnancy	$5,000
Organ Transplant - **Benefit Area "C"** (lifetime maximum benefit)	$150,000
Skilled Nursing Facility - **Benefit Area "C"** (annual benefit maximum)	45 days
Rehabilitation Therapy - **Benefit Area "C"** (annual inpatient benefit maximum)	$25,000
Rehabilitation Therapy - **Benefit Area "D"** (combined annual outpatient benefit max)	$2,000
Home Health Care Benefits - **Benefit Area "D"** (annual benefit maximum)	$5,000
Hospice Care - **Benefit Area "D"** (annual benefit maximum)	$5,000
Ambulance Service - **Benefit Area "E"** (annual benefit maximum)	$2,000
Durable Medical Equipment - **Benefit Area "E"** (annual benefit maximum)	$10,000
Psychiatric and Substance Abuse Services - **Benefit Area "F"** Covered benefit as an inpatient or outpatient combined (annual benefit maximum)	$5,000

CATASTROPHIC "B" BENEFIT PLAN	
Pharmacy - **Benefit Area "G"**	
Calendar Year Pharmaceutical Deductible - Individual	$500
Benefit Percentage	50%
Coinsurance Percentage Does not apply to Out-of-Pocket Expense limit	50%

(1-1-01)T

013. -- 999. (RESERVED).

ATTACHMENT A
STANDARD BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	$100,000
Benefit Area A	
Preventive Services	
Copayment: -Adults -Children	 $15 $0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum	$250
Benefit Areas B1, C, D, E, F,G	
Calendar Year Deductible	
-Individual -Family -Maternity (additional deductible)	$1,000 $2,000 $1,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Out-of-Pocket Expense Limit -Individual -Family	 $5,000 $10,000
Emergency Ambulance Service Annual Benefit Maximum	 $750
Durable Medical Equipment Annual Benefit Maximum	 $15,000

SCHEDULE OF BENEFITS	
All Benefit Areas	
Psychiatric and Substance Abuse Services Annual Benefit Maximum Maximum benefit payable during calendar year	$5,000
Benefit Area G	
Drugs and Pharmaceuticals Coinsurance - for each prescription for up to a 30-day supply (formularies permitted)	80%

ATTACHMENT B
BASIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	$25,000
Benefit Area A	
Preventive Services	
Copayment: -Adults -Children under Age 12	 $15 $0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum	$250
Benefit Areas B, C, D, E, F, G	
Calendar Year Deductible	
- Individual - Family	$2,500 $5,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Out-of-Pocket Expense Limit - Individual - Family	 $5,000 $10,000
Emergency Ambulance Service Annual Benefit Maximum	 $750
Durable Medical Equipment Annual Benefit Maximum	 $15,000

SCHEDULE OF BENEFITS	
All Benefit Areas	
Psychiatric and Substance Abuse Services Annual Benefit Maximum - Outpatient Maximum benefit payable during calendar year	 $2,500
Benefit Area G	
Drugs and Pharmaceuticals Coinsurance - for each prescription, for up to a 30-day supply (formularies permitted)	 50%

ATTACHMENT C

MANAGED CARE CATASTROPHIC PLAN DESIGN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	$200,000
Calendar Year Out-of-Pocket Expense Limits	
(For Copayments and Coinsurance:) -per person -per family	 $12,000 $24,000
The per person Benefit Maximum applies when family coverage is purchased. Copayments - Only as stated for specific Benefit Areas Coinsurance - Only as stated for specific Benefit Areas	
Benefit Area A -	
Preventive Services	
Copayment - per visit: -Adults -Children	 $20 $0
Preventive Services Annual Benefit Maximum	$250
Benefit Area B	
Maternity	
-Outpatient Maternity Copayment per Visit	$20
-Outpatient Maternity Out-of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)	$240
-Inpatient Maternity Copayment per Day per Pregnancy	$500
-Inpatient Maternity Out-of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)	$1,000
Benefit Area C	

SCHEDULE OF BENEFITS	
All Benefit Areas	
General Inpatient Services	
Copayment per Day (not to exceed 5 days per admission)	$500
-Out-of-Pocket Expense Limit per Admission	$2,500
Benefit Area D	
General Outpatient Services	
Copayment per Office Visit	$20
Copayment for Laboratory and Radiology (x-ray)	$0
Benefit Area E	
Transportation and Medical Equipment	
Ambulance	
-Coinsurance per Trip	50%
-Annual Benefit Sub-maximum	$750
Durable Medical Equipment	
-Coinsurance	50%
-Annual Benefit Sub-maximum	$10,000
Benefit Area F	
Psychiatric and Substance Abuse	
Outpatient Services (not including drugs which are covered under Area G)	
-Copayment per Visit	$50
-Annual number of Covered Visits	10
Inpatient Services (including drugs)	
-Copayment per Day	$400
-Annual maximum number of Covered Days	10
Benefit Area G	
Drugs and Pharmaceuticals	
-Coinsurance - for each prescription, for up to a 30-day supply (formularies permitted	50%

ATTACHMENT D

CATASTROPHIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Individual Benefit Maximum	$200,000
Calendar Year Deductible	

SCHEDULE OF BENEFITS	
All Benefit Areas	
-Individual -Family	$2,000 or $5,000 $4,000 or $10,000
Benefit Percentage	50%
Coinsurance Percentages	50%
Calendar Year Out-of-Pocket Expense Limit	
-Individual	$10,000 for $2,000 deductible $13,000 for $5,000 deductible
-Family	$20,000 for $4,000 deductible $26,000 for $10,000 deductible

Change to Higher Deductible - Charges previously applied to deductible amount for the same year are applied to the new deductible amount. New covered charges are applied to the new deductible amount. Change to lower deductible is not permitted. Charges applied to the deductible amount are not carried over to the next calendar year.

Benefit Area A	
Preventive Services Annual Benefit Maximum	 $250
Benefit Areas B1, C, D, E, F	
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
Benefit Area G	
Pharmacy Benefits Coinsurance - for each prescription, for up to a 30 day supply (formularies permitted)	 50%

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