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18.01.73 - Rule to Implement the Individual Health Insurance Availability Act Plan Design

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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. (3-15-02)

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". (3-15-02)

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. (3-15-02)

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, with the exception of the HSA. (4-11-06)

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. (3-15-02)

06. Out-of-Pocket Expense Maximum. Out-of-pocket expense maximum is the maximum medical expense that an insured is obligated to pay, which includes coinsurance as defined in the schedule of benefits. Under the Basic, Standard, and Catastrophic A and B health benefit plans, the out-of-pocket expense maximum does not include deductibles, copayments, pharmacy expenses, expenses for non-covered services and supplies, and charges in excess of the eligible expense. After the out-of-pocket expense maximum has been reached, covered services will be

provided at one hundred percent (100%) except for specific deductibles, copayments, pharmacy benefits, non-covered services and supplies, and charges in excess of the eligible expense. HSA annual out-of-pocket expense maximum, subject to any policy limitations, or ineligible out-of-pocket expenses, includes deductibles, copayments, and coinsurance including pharmacy expenses. After the HSA out-of-pocket expense maximum has been reached, covered services will be provided at one hundred percent (100%) with the exception of services, supplies, and charges in excess of the eligible expense. (4-11-06)

- 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: (3-15-02)
- a.** Licensed general hospital; (3-15-02)
 - 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. (3-15-02)
 - 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). (3-15-02)
- 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: (3-15-02)
- a.** For a service or supply which is not medically necessary; (3-15-02)
 - b.** Which is in excess of reasonable and customary charge for a service or supply; (3-15-02)
 - c.** Which is in excess of any contractual arrangements; (3-15-02)
 - 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 (3-15-02)
 - e.** For which no charge or a different charge is usually made in the absence of insurance coverage. (3-15-02)
- 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: (3-15-02)
- 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. (3-15-02)

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: (3-15-02)

a. Placing the Insured's health in serious jeopardy; (3-15-02)

b. Serious impairment to bodily functions; or (3-15-02)

c. Serious dysfunction of any bodily organ or part. (3-15-02)

005. -- 009. (RESERVED).

010. COORDINATION OF BENEFITS.

Coordination of Benefits shall be utilized on the Individual basic, standard, and catastrophic A, catastrophic B plans, and HSA compatible benefit plans based upon IDAPA 18.01.74, "Coordination of Benefits". (4-11-06)

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. (3-15-02)

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. (3-15-02)

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. (3-15-02)
- 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. (3-15-02)
- 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. (3-15-02)
- 13. Dental, Temporomandibular 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. (3-15-02)
- 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. (3-15-02)
- 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. (3-15-02)
- 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. (3-15-02)
- 21. Acupuncture.** Acupuncture, except when used as pain management by a licensed provider. (3-15-02)
- 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. (3-15-02)
- 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. (3-15-02)
- 31. Maternity.** Not a covered benefit under the HSA Compatible Plan. (4-11-06)
- 32. Expenses Exceeding the Carrier's Allowable Amount.** Expenses and/or charges which exceed the carrier's allowable amount for a service or supply. (4-11-06)

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: (3-15-02)

| 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 and 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 Copayments | \$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 Maximum | \$2,000 |

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

(3-15-02)

| STANDARD 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 | \$1,000 |
| Benefit Percentage | 70% |
| Coinsurance Percentage | 30% |
| Individual Out-of-Pocket Expense Maximum not including Deductible or Copayments | \$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 Maximum | \$2,000 |

| STANDARD BENEFIT PLAN | |
|--|----------|
| 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 |
| 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% |

(3-15-02)

| 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 Copayments | \$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 Maximum | \$2,000 |

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

(3-15-02)

| 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 Copayments | \$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 Maximum | \$2,000 |

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

(3-15-02)

| HSA – COMPATIBLE 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 C, D, E, F | |
| Calendar Year Deductible - Individual | \$3,000 |
| Family | \$6,000 |
| Benefit Percentage | 60% |
| Coinsurance Percentage | 40% |
| Individual Out-of-Pocket Expense Maximum including Deductible or copayments, and coinsurance | \$5,000 |
| Family Out-of-Pocket Expense Maximum | \$10,000 |
| Maternity Benefit - Benefit Area "B" Not available under the HSA Compatible Benefit Plan | Not Covered |
| 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 Maximum | \$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 |
| Pharmacy - Benefit Area "G" Calendar Year Pharmaceutical Subject to Deductible and Coinsurance | \$6,000 |

(4-11-06)

013. -- 999. (RESERVED).

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