Table of Contents

IDAPA 18
TITLE 01
CHAPTER 70

18.01.70 - RULES GOVERNING SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT PLAN DESIGN

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 18.01.70, "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(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.
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 a condition, whether physical or mental, regardless of the cause of the 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. (7-1-98)

b. Genetic information shall not be considered as a condition described in Subsection 010.10 in the absence of a diagnosis of the condition related to such information. (7-1-98)

c. 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 sixty-three (63) 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. (7-1-98)

d. 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, and Chapter 39, Title 41, Idaho Code, to provide health care services to covered individuals. (7-1-98)

005. -- 014. (RESERVED)

015. COORDINATION OF BENEFITS.
Coordination of benefits shall be utilized on the small employer basic, standard, and catastrophic plans based upon IDAPA 18.01.74, "Coordination of Benefits." (3-15-02)

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 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 anomaly. Mastectomy reconstruction is covered as described in the Womens Health and Cancer Rights Act. (3-15-02)

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), except in catastrophic health benefit plans. (7-1-98)

11. Limitation Foot Care. For treatment of weak, strained, or flat feet, including orthopedic shoes 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. (7-1-98)

12. Manipulative Therapy and Related Treatment. Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to one thousand dollars ($1,000) per year limit, subject to the policy deductible, co-insurance, or co-payment. (4-5-00)

13. Dental, Orthodontic Services. (7-1-98)

a. For Basic and Standard plans: 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). (7-1-98)

b. For Catastrophic plans: Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. (7-1-98)

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 Insured's 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. (7-1-98)

a. For Basic and Standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. (7-1-98)

b. For Catastrophic plans: Acupuncture. (7-1-98)

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. Services incurred after the date of termination of a covered person's coverage except as allowed by the extension of benefits provision of the policy, if any. (7-1-98)

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

017. -- 999. (RESERVED)

APPENDIX A
MANAGED CARE STANDARD BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	**$100,000**
Preventive Services (Benefit Area A)	
Copayment: -Adults -Children	 $15 $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

SCHEDULE OF BENEFITS	
All Benefit Areas	
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%

SCHEDULE OF BENEFITS	
All Benefit Areas	
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 -Children	 $15 $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	

SCHEDULE OF BENEFITS	
All Benefit Areas	
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
MANAGED CARE BASIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	$25,000
Preventive Services (Benefit Area A)	
Copayment -Adults -Children	 $15 $0
Benefit Percentage	100%

SCHEDULE OF BENEFITS	
All Benefit Areas	
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)	

SCHEDULE OF BENEFITS	
All Benefit Areas	
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 -Children under Age 12	 $15 $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

SCHEDULE OF BENEFITS	
All Benefit Areas	
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.

APPENDIX E
MANAGED CARE CATASTROPHIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	$200,000
Calendar Year Out-of-Pocket Limits	

SCHEDULE OF BENEFITS	
All Benefit Areas	
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 - Adults - Children	 $20 $0
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 **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 -Annual Benefit Sub-maximum	 50% $750
Durable Medical Equipment -Coinsurance -Annual Benefit Sub-maximum	 50% $10,000

SCHEDULE OF BENEFITS	
All Benefit Areas	
Benefit Area F	
Psychiatric and Substance Abuse	
Outpatient Services (not including drugs 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 - subjects unlisted drugs to managed care plan approval)	50%

APPENDIX F
CATASTROPHIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Individual Benefit Maximum	$200,000
Calendar Year Deductible	
Individual	$2,000 or $5,000
Family	$4,000 or $10,000
Benefit Percentage	50%
Coinsurance Percentage	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*	 $500
BENEFIT AREAS B2, 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 Copayment per Prescription Benefit Percentage Coinsurance	 $10 100%** 0%**

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

** 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, 100% of the cost of the brand name drug after the copayment is payable.

Subject Index