IDAPA 18
TITLE 04
CHAPTER 08

18.04.08 - INDIVIDUAL DISABILITY AND GROUP SUPPLEMENTAL DISABILITY INSURANCE MINIMUM STANDARDS RULE

000. LEGAL AUTHORITY.
This rule is issued pursuant to the authority vested in the Director under ~~Chapter 42,~~ Title 41, Chapters 2, 42 and 52, Idaho Code, and ~~Chapter 52,~~ Title 67~~-5220(1)~~, Chapter 52, Idaho Code. (~~3-30-01~~)(_____)

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.30, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule." (3-30-01)

02. Scope. The purpose of this rule is to implement ~~Chapter 42,~~ Title 41, Chapters 21, 22, 34, 39, 42, 52 and 55, Idaho Code, and, to th~~is~~e extent not in conflict with federal law, to standardize and simplify the terms and coverages of individual disability insurance policies, and group supplemental health insurance consisting of group disability policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage. This rule is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims, and to provide for full disclosure in the marketing and sale of individual accident and sickness insurance policies and group supplemental health insurance. This rule is also intended to provide for disclosure in the sale of dental and vision plans. The term "disability" is limited to "accident and sickness," unless otherwise specified herein. (~~3-30-01~~)(_____)

03. Application. This rule applies to all individual accident and sickness insurance policies and group supplemental health policies and certificates, including nonrenewable short-term plans issued for a period of twelve (12) months or less, offered, delivered, ~~or~~ issued for delivery, continued or renewed in this state on and after the effective date of this rule that are not specifically exempted from the rule. (~~3-30-01~~)(_____)

a. This rule shall apply to disability income protection plans, dental plans and vision plans only as specified herein. (~~3-30-01~~)(_____)

b. In regard to supplemental insurance, this rule shall apply to group supplemental plans whether issued to supplement group accident and sickness insurance, or as a supplemental plan that pays benefits regardless of other coverage. (~~3-30-01~~)(_____)

~~b~~**c.** This rule shall not apply to: (~~3-30-01~~)(_____)

i. Individual policies or contracts issued pursuant to a conversion privilege under a group policy or ~~contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this rule~~ certificate. (~~3-30-01~~)(_____)

ii. Policies issued to employees or members as additions to franchise plans ~~in existence on the effective date of this rule~~. (~~3-30-01~~)(_____)

iii. Medicare supplement policies subject to ~~Chapter 44,~~ Title 41, Chapter 44, Idaho Code, Medicare Supplement Insurance Minimum Standards, and IDAPA 18.01.54, "Rule to Implement the NAIC Medicare

Supplement Insurance Minimum Standards Model Act." (3-30-01)(_____)

iv. Long-term care insurance policies subject to Chapter 46, Title 41, Chapter 46, Idaho Code, Long Term Care Insurance, and IDAPA 18.01.60, "Long-Term Care Insurance Minimum Standards." (3-30-01)(_____)

v. Civilian Health and Medical Program of the Uniformed Services, Chapter 55, Title 10, Chapter 55 of the United States Code, (CHAMPUS) supplement insurance policies. (3-30-01)(_____)

04. Other Rules Applicable. The requirements contained in this rule shall be in addition to any other applicable rules previously adopted. (3-30-01)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201, Idaho Code, this agency may have written statements that 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 at this agency. (3-30-01)(_____)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Chapter 2, Idaho Code, Chapter 52, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General." (3-30-01)(_____)

0054. INCORPORATION BY REFERENCE.

01. Copies. Copies of these documents incorporated by reference may be obtained from the Idaho Department of Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, Idaho 837020-0043, or from the Internet website at www. doi.state.id.us under the "Consumer Assistance" linkdoi.idaho.gov. (3-30-01)(_____)

02. Documents Incorporated by Reference. The following sectionsOutlines of Coverage and required notices are incorporated into this rule from of the April 1999 version of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act are incorporated by reference into these rules: (3-30-01)(_____)

a. Basic Hospital Expense Coverage. (3-30-01)

b. Basic Medical-Surgical Expense Coverage. (3-30-01)

c. Basic Hospital/Medical-surgical Expense Coverage. (3-30-01)

d. Hospital Confinement Indemnity Coverage. (3-30-01)

e. Individual Major Medical Expense Coverage. (3-30-01)

fe. Disability Income Protection Coverage. (3-30-01)

gf. Accident Only Coverage. (3-30-01)

hg. Specified Disease Or Specified Accident Coverage. (3-30-01)

ih. Limited Benefit Health Coverage. (3-30-01)

i. Nonrenewable Short Term Coverage. (_____)

j. Dental Plans. (_____)

k. Vision Plans. (_____)

~~l. Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance (direct sales). (3-30-01)~~

~~m. Notice To Applicant Regarding Placement Of Accident And Sickness Insurance (other than direct sales). (3-30-01)~~

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEBSITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (_____)

02. Mailing Address. The Department's mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (_____)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702. (_____)

04. Website Address. The Department's web address is https://doi.idaho.gov. (_____)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. (_____)

006~~7~~. -- 0~~1~~09. (RESERVED) (~~3-30-01~~)(_____)

00~~4~~10. DEFINITIONS.

Except as provided in this rule, an individual accident and sickness insurance policy or group supplemental health insurance policy or certificate delivered, ~~or~~ issued for delivery, continued or renewed ~~to any person~~ in this state and to which this rule applies shall ~~contain~~ include definitions ~~respecting the matters set forth below that comply with the requirements of Section 00410.~~ no more restrictive than the following: (~~3-30-01~~)(_____)

01. Accident. "Accident," "accidental injury," and "accidental" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (3-30-01)

a. The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. (3-30-01)

b. The definition may ~~provide that~~ exclude injuries ~~shall not include injuries~~ for which benefits are provided: (~~3-30-01~~)(_____)

i. ~~Benefits are provided u~~Under workers' compensation, employers' liability, or similar law; or (~~3-30-01~~)(_____)

ii. Under a motor vehicle no-fault plan, unless ~~prohibited by law~~the motor vehicle no-fault plan provides for coordination of benefits; or (~~3-30-01~~)(_____)

iii. For i~~I~~njuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. (~~3-30-01~~)(_____)

02. Accident Only Coverage. "Accident Only Coverage" means a policy or certificate that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by an accident. (_____)

03. Basic Hospital Expense Coverage. "Basic Hospital Expense Coverage" means a policy or certificate of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured, for expenses incurred for medically necessary treatment and services rendered as a result of accident or sickness. ( )

04. Basic Hospital/Medical-Surgical Expense Coverage. "Basic Hospital/Medical-Surgical Expense Coverage" means a policy or certificate of combined coverage that must meet the requirements of both Sections 013 and 014 of this rule. ( )

05. Basic Medical-Surgical Expense Coverage. "Basic Medical-Surgical Expense Coverage" means a policy or certificate of accident and sickness insurance that provides coverage for each person insured for the expenses incurred for the medically necessary services for treatment of an injury of sickness. ( )

026. Convalescent Nursing Home. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facility and available services. (~~3-30-01~~)( )

a. A definition of the home or facility shall not be more restrictive than one requiring that it: (3-30-01)

i. Be operated pursuant to law; (3-30-01)

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; (3-30-01)

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (3-30-01)

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and (3-30-01)

v. Maintain a daily medical record of each patient. (3-30-01)

b. The definition of the home or facility may provide that the term shall not be inclusive of: (3-30-01)

i. A home, facility or part of a home or facility used primarily for rest; (3-30-01)

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or (3-30-01)

iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care. (3-30-01)

07. Dental Coverage. "Dental Coverage" means a policy or certificate that primarily provides benefits for dental expenses. ( )

08. Disability Income Protection Coverage. "Disability Income Protection Coverage" means a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of both. ( )

09. Home Health Care Agency. "Home Health Care Agency" means an agency approved under Medicare, or that is licensed to provide home health care under applicable state law, or meets all of the following requirements: ( )

i. It is primarily engaged in providing home health care services; ( )

ii. Its policies are established by a group of professional personnel (including at least one (1)

physician and one (1) registered nurse); ( )

iii. A physician or a registered nurse provides supervision of home health care services; ( )

iv. It maintains clinical records on all patients; and ( )

v. It has a full time administrator. ( )

10. Hospice. "Hospice" means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: ( )

a. For terminally ill patients whose life expectancy is less than six (6) months; ( )

b. Provided on an inpatient or outpatient basis; and ( )

c. Directed by a physician. ( )

03 11. Hospital. "Hospital" ~~M~~may shall be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation of Rehabilitation Facilities or by Medicare. (~~3-30-01~~)( )

a. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (3-30-01)

i. Be an institution licensed to operate as a hospital pursuant to law; (3-30-01)

ii. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and (3-30-01)

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. (3-30-01)

b. The definition of the term "hospital" ~~may state that the term~~ shall not be inclusive of the following, unless the facility otherwise meets the qualifications set forth at ~~Subsection~~ Paragraph 0~~4~~10.0~~3~~11.a. of this rule:

(~~3-30-01~~)( )

i. Convalescent homes or, convalescent, rest, or nursing facilities; (3-30-01)

ii. Facilities affording primarily custodial, educational, or rehabilitory care; (3-30-01)

iii. Facilities for the aged, drug addicts, or alcoholics; or (3-30-01)

iv. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. (3-30-01)

12. Hospital Confinement Indemnity Coverage. "Hospital Confinement Indemnity Coverage" means a policy or certificate of accident and sickness insurance that provides daily benefits for hospital confinement on an indemnity basis. ( )

13. Individual Major Medical Expense Coverage. "Individual Major Medical Expense Coverage" means a non-group policy of accident and sickness insurance that provides hospital, medical and surgical expense

coverage. ( )

14. Investigational. "Investigational" shall not be defined more restrictively than any treatment, procedure, facility, equipment, drug, device or commodity, regardless of its medical necessity, which is experimental, or in the early developmental state of medical technology, for which there are no randomized clinical trials or, absent such trials, for which there are no cohort studies or case-control studies or, absent such studies, then for which there is no case-series. The determination by the insurer will be based on objective data and information obtained by the insurer and reviewed by competent medical personnel, according to the following: ( )

a. The technology has final approval from the appropriate regulatory bodies; ( )

b. Medical or scientific evidence regarding the technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the technology; ( )

c. The technology's overall beneficial effects on health outweigh the overall harmful effects on health; and ( )

d. The technology is as beneficial as any established alternative. ( )

When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of Paragraphs 010.14.c and 010.14.d. ( )

15. Limited Benefit Health Coverage. "Limited Benefit Health Coverage" means a policy or certificate that provides benefits that are less than the minimum standards for benefits required under Sections 013 through 017, 019, 021 and 023 of this rule. ( )

16. Medically Necessary or Medical Necessity. "Medically Necessary" or "Medical Necessity" shall not be defined more restrictively than health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to an insured person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are: ( )

a. In accordance with generally accepted standards of medical practice; ( )

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the insured person's illness, injury or disease: ( )

c. Not primarily for the convenience of the insured person, physician or other health care provider, and ( )

d. Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the insured person's illness, injury or disease. ( )

~~04~~**17. Medicare**. "Medicare" ~~M~~means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. (~~3-30-01~~)( )

~~05~~**18. Mental or Nervous Disorders**. "Mental Disorders" or "Nervous Disorders" ~~S~~shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. (~~3-30-01~~)( )

~~06~~**19. Nurse**. "Nurse" ~~M~~may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Idaho. (~~3-30-01~~)( )

~~07~~20. **One Period of Confinement**. "One Period of Confinement" ~~M~~means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days. (~~3-30-01~~)(_____)

~~08~~21. **Partial Disability**. "Partial Disability" ~~S~~shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important" or "essential" duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation.(~~3-30-01~~)(_____)

~~09. **Physician**. May be defined by including words such as "qualified physician" or "licensed physician." The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~ (~~3-30-01~~)

~~10~~22. **Preexisting Condition**. "Preexisting Condition" ~~S~~shall not be defined more restrictively than ~~the following:~~ 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, or 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. A policy or certificate (~~3-30-01~~)

~~a.~~ ~~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 preexisting condition. ~~A health benefit plan shall not define a preexisting condition more restrictively than:~~ (~~3-30-01~~)(_____)

~~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;~~ (~~3-30-01~~)

~~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~~ (~~3-30-01~~)

~~iii. A pregnancy existing on the effective date of coverage.~~ (~~3-30-01~~)

~~b. A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage 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.~~ (~~3-30-01~~)

~~c. An individual carrier shall not modify a health benefit plan with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.~~ (~~3-30-01~~)

23. **Provider.** "Provider" means a person or entity that is licensed, where required, to provide health care or related services. (_____)

~~11~~24. **Residual Disability**. "Residual Disability" ~~S~~shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the Director adequately and fairly describes the benefit. (~~3-30-01~~)(_____)

25. Short Term Coverage. "Short Term Coverage" means a policy or certificate that provides nonrenewable accident and sickness coverage for a period of twelve (12) months or less. ( )

~~12~~**26. Sickness or Illness**. "Sickness or Illness" ~~S~~shall not be defined to be more restrictive than the following: "Sickness (or Illness) means sickness or disease of an insured person that ~~first manifests~~ presents itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law." (~~3-30-01~~)( )

27. Specified Accident Coverage. "Specified Accident Coverage" means a policy or certificate that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the coverage for accidental death or accidental death and dismemberment combined. ( )

28. Specified Disease Coverage. "Specified Disease Coverage" means a policy or certificate that pays benefits for the diagnosis and treatment of a specifically named disease or diseases. ( )

~~13~~**29. Total Disability**. "Total Disability" ~~S~~shall be defined in accordance with the following limitations: (~~3-30-01~~)( )

a. A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. (3-30-01)

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (3-30-01)

i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or (3-30-01)

ii. Engage in a training or rehabilitation program. (3-30-01)

c. An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family. (3-30-01)

30. Usual, Customary and Reasonable Charges. "Usual," "Customary" and "Reasonable" charges mean the following: ( )

a. "Usual charge" means the most consistent charge by a provider for a given service. ( )

b. "Customary charge" means a charge within the range of usual charges for a given service billed by most providers with similar training and experience taking into consideration the geographic area in which the services are provided and significant regional variations in the costs of services. ( )

c. "Reasonable charge" means a charge that is the usual and customary charge. ( )

31. Vision Coverage. "Vision Coverage" means a policy or certificate that primarily provides benefits for vision expenses. ( )

011. PROHIBITED POLICY PROVISIONS.

01. Probationary or Waiting Period. Except as provided in Subsection 0~~0~~410.~~10~~23 pertaining to the definition of a preexisting condition, a policy or certificate shall not contain provisions establishing a probationary

or waiting period during which no coverage is provided under the policy or certificate except as allowed by Paragraph 020.03.c. regarding specified disease coverage. Accident policies shall not contain probationary or waiting periods. (~~3-30-01~~)(____)

02. Additional Coverage as Dividend. A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months. (3-30-01)

a. The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional. (3-30-01)

03. Return of Premium or Cash Value Benefit. ~~A disability income policy or hospital confinement indemnity policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate.~~ No ~~other~~ policy or certificate, other than disability income or hospital confinement ~~subject to this rule~~ shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds. (~~3-30-01~~)(____)

~~**04. Federally Operated Hospital**. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.~~ (~~3-30-01~~)

0~~5~~4. Exclusions. A policy or certificate shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~ that a policy or certificate may include one or more of the following limitations or exclusions: (~~3-30-01~~)(____)

a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child; (3-30-01)

b. Mental or emotional disorders, alcoholism and drug addiction; (3-30-01)

c. Pregnancy, except for complications of pregnancy; (3-30-01)

d. Illness, treatment or medical condition arising out of: (3-30-01)

i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (3-30-01)

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (3-30-01)

iii. Professional ~~A~~aviation for wage or profit; and (~~3-30-01~~)(____)

~~iv. With respect to short-term nonrenewable policies, interscholastic sports; and~~ (~~3-30-01~~)

~~vi~~v. With respect to disability income protection policies, incarceration. (~~3-30-01~~)(____)

e. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part~~, and~~; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications or complications related to a cosmetic procedure; (~~3-30-01~~)(____)

f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (3-30-01)

g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; (3-30-01)

h. Benefits ~~provided under~~ in excess of Medicare eligible expense, if enrolled in Medicare or other governmental program (except Medicaid), or benefits provided under a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law unless the motor vehicle no-fault plan provides for coordination of benefits; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; (~~3-30-01~~)( )

i. Dental care or treatment; (3-30-01)

j. Eye glasses, hearing aids, and examination for the prescription, or fitting of them; (3-30-01)

k. Rest cures, custodial care, transportation, and routine physical examinations; (3-30-01)

l. Territorial limitations~~.~~**;** (~~3-30-01~~)( )

m. Missed or cancelled appointments; completion of claim forms or records copying; failure to vacate a room on or before the facility's established discharge hour; educational and training services except as provided by the policy or certificate; over the counter medical supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, alcohol swabs or dressings; ( )

n. Charges in excess of: ( )

i. Usual, customary and reasonable charges for noncontracting providers; or ( )

ii. The rate agreed to between the insurer and provider for contracting providers; ( )

o. Treatment, services or supplies not prescribed by or upon the direction of a licensed provider, acting within the scope of his or her license; ( )

p. Services rendered prior to the effective date of coverage or after termination of coverage, except as provided by an extension of benefits provision, and; ( )

q. The reversal of an elective sterilization procedure, including but not limited to vasovasostomies or salpingoplasties. ( )

0~~6~~5. Authority of Director to Disapprove. Policy provisions precluded in Section 011 shall not be construed as a limitation on the authority of the Director to disapprove other policy provisions in accordance with ~~Chapters 21, 22 and 42 of~~ Title 41, Chapters 21, 22 and 42 of the Idaho Code, or that in the opinion of the Director are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy. (~~3-30-01~~)( )

Accident and Sickness Minimum Standards for Benefits
(Sections 012 through 02~~9~~4)

01~~3~~2. GENERAL RULES. The following subsections apply to all policies and certificates subject to this rule. (~~3-30-01~~)( )

~~012~~. 01.~~ACCIDENT AND SICKNESS MINIMUM STANDARDS FOR BENEFITS.~~ The following minimum standards for benefits are prescribed for the categories of coverage noted in ~~the following sub~~sections 013 through 025 of this rule. An individual accident and sickness insurance policy or group supplemental health insurance policy or certificate shall not be offered, delivered or issued for delivery, continued or renewed in this

state unless it meets the required minimum standards for the specified categories or the Director finds that the policies or contracts are allowable as limited benefit health insurance. and tThe outline of coverage shall complies with the model outline of coverage established by the National Association of Insurance Commissioners ("NAIC") and accessible by the Internet at www.doi.state.id.us, under the "Consumer Assistance" link, for each category of coverage noted in Sections 013 through 0295. Section 012 shall not preclude the issuance of any policy or contract combining two (2) or more categories set forth in Section 41-4204(1) and 41-4204(2), Idaho Code. Limitations on coinsurance percentages set forth in this rule do not apply to out-of-network benefits offered as part of a managed care plan. (3-30-01)( )

a. The exclusions shall not be more restrictive than stated in Subsection 011.04. ( )

b. The preexisting condition definition shall not be more restrictive than as defined in this Chapter. ( )

c. The contract language shall not be more restrictive than Sections 011 and 012 of this Chapter. ( )

d. Benefits shall be paid regardless of other coverage, except for individual major medical expense coverage. ( )

e. The applications for coverage shall meet the requirements of Paragraph 101.01.a. ( )

f. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident or sickness insurance. ( )

012. Termination of Coverage of Spouse Limitations Renewability. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual accident and sickness policy or group supplemental health insurance policy or certificate shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured. (3-30-01)( )

a. The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 101 of this rule. (3-30-01)

b. The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual accident and sickness policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. (3-30-01)( )

c. An individual accident and sickness or individual accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed. The renewability provision in an individual accident and sickness insurance policy or group supplemental accident and sickness health insurance policy or certificate shall not be more restrictive than Paragraph 101.01.b. of this Chapter. (3-30-01)( )

d. Except as provided in Section 0132 of this rule, (the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums and, except for individual major medical expense coverage, until the age of sixty-five (65) or until eligibility for Medicare and to the extent not in conflict with the federal Health Insurance Portability and Accountability Act, (HIPAA), during

which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except where the insurer is able to show good cause for changing the policy provisions and obtains prior written approval from the Director. The insurer may make changes in premium rates ~~by classes~~. (~~3-30-01~~)(_____)

0~~2~~3. Age and Durational Requirements. In an individual accident and sickness policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this ~~requirement~~ provision shall not ~~prevent~~ require termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse as the insured person to the age or for the durational period as specified in the policy. (~~3-30-01~~)(_____)

0~~3~~4. Accidental Death and Dismemberment Coverage. When accidental death and dismemberment coverage is part of the individual accident and sickness insurance coverage offered under the contract, the primary insured shall have the option to include all insureds under the coverage ~~and not just the principal insured~~. (~~3-30-01~~)(_____)

0~~4~~5. Military Service Limitations. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis. (~~3-30-01~~)(_____)

0~~5~~6. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. (~~3-30-01~~)(_____)

0~~6~~7. Convalescent or Extended Care Benefits. Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital. (~~3-30-01~~)(_____)

0~~7~~8. Coverage of Dependents. A policy's coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation~~ intellectual or physical ~~handicap~~ disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. Provisions relating to coverage of dependents with ~~mental~~ intellectual or physical ~~handicaps~~ disabilities shall meet the requirements of Sections 41-2139 and 41-2203, Idaho Code. (~~3-30-01~~)(_____)

~~08~~9. Expenses of Live Donor. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid. (~~3-30-01~~)(_____)

~~09~~10. Recurrent Disabilities. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months. (~~3-30-01~~)(_____)

~~10~~11. Accidental Death and Dismemberment. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. ~~Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.~~ (~~3-30-01~~)(_____)

~~11~~12. Specific Dismemberment Benefits. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits. (~~3-30-01~~)(_____)

~~12. Accident Only Policy~~. ~~An accident only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.~~ ~~(3-30-01)~~

13. ~~**Continuous Loss.**~~ **Extension of Benefits.** Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits. (~~3-30-01~~)(_____)

14. Fractures or Dislocations. A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations. (3-30-01)

15. Conditions or Complications. A policy or certificate providing coverage for accident or sickness shall also provide reimbursement of any medically necessary expenses as a result of a condition or complication of a service for which coverage is not provided in the policy or certificate. (_____)

16. Discretionary Clauses. All policies and certificates must comply with IDAPA 18.01.029, "Restrictions on Discretionary Clauses in Health Insurance Contracts". (_____)

17. Advertising Requirement. Advertising materials for all plans subject to this Rule shall be filed with the Department and must be in compliance with IDAPA 18.01.24, "Advertisement of Disability (Accident and Sickness) Insurance". (_____)

0143. BASIC HOSPITAL EXPENSE COVERAGE.

~~A policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~ ~~(3-30-01)~~

01. Minimum Standards for Benefits. The following minimum standards apply: (_____)

~~01~~**a.** ~~**Daily Hospital Room and Board.**~~ Daily hospital room and board in an amount not less than the lesser of: (~~3-30-01~~)(_____)

~~a~~i. Eighty percent (80%) of the charges for semiprivate room accommodations; or (~~3-30-01~~)(_____)

~~b~~ii. One hundred dollars ($100) per day. (~~3-30-01~~)(_____)

~~02~~**b.** ~~**Miscellaneous Services.**~~ Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either eighty percent (80%) of the charges incurred up to at least three thousand dollars ($3,000) or ten (10) times the daily hospital room and board benefits; and (~~3-30-01~~)(_____)

~~03~~**c.** ~~**Hospital Outpatient Services.**~~ Hospital outpatient services consisting of: (~~3-30-01~~)(_____)

~~a~~i. Hospital services on the day surgery is performed; (~~3-30-01~~)(_____)

~~b~~ii. Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than one hundred fifty dollars ($150); and (~~3-30-01~~)(_____)

~~c~~iii. X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than one hundred dollars ($100) if rendered to an in-patient of the hospital. (~~3-30-01~~)(_____)

~~04~~**d.** ~~**Combined Deductible.**~~ Benefits provided under Subsections 0143.01 and 0143.02 of this rule may be provided subject to a combined deductible amount not in excess of one hundred dollars ($100).(~~3-30-01~~)(_____)

02. Required Disclosure Provisions. All basic hospital expense policies and certificates shall display prominently on the first page of the policy or certificate in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a basic hospital expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (_____)

015~~5~~4. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE.

~~A policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:~~ ~~(3-30-01)~~

01. Minimum Standards for Benefits. The following minimum standards apply: (_____)

~~01~~a. ~~Surgical Services.~~ Surgical services shall be in an amount not less than the lesser of: (~~3-30-01~~)(_____)

~~a~~i. In amounts not less than those provided on a fee schedule based on the relative values contained in the most recent Medicare Resource Based Relative Value Scale, as amended, or as defined to the Director, utilizing Current Procedure Terminology (CPT) coding or other acceptable relative value schedule, up to a maximum of at least one thousand dollars ($1000) for one procedure; or (~~3-30-01~~)(_____)

~~b~~ii. Not less than eighty percent (80%) of the reasonable charges. (~~3-30-01~~)(_____)

~~02~~b. ~~Anesthesia Services.~~ Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services in an amount not less than the lesser of: (~~3-30-01~~)(_____)

~~a~~i. Eighty percent (80%) of the reasonable charges; or (~~3-30-01~~)(_____)

~~b~~ii. Fifteen percent (15%) of the surgical service benefit. (~~3-30-01~~)(_____)

~~03~~c. ~~In-Hospital Medical Services.~~ In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than the lesser of: (~~3-30-01~~)(_____)

~~a~~i. Eighty percent (80%) of the reasonable charges; or (~~3-30-01~~)(_____)

~~b~~ii. Fifty dollars ($50) per day for not less than twenty-one (21) days during one period of confinement. (~~3-30-01~~)(_____)

02. Required Disclosure Provisions. All basic medical-surgical expense policies and certificates shall display prominently on the first page of the policy or certificate in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a basic medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (_____)

016~~5~~. BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE.

01. A combined coverage ~~and~~ must meet the requirements of both Sections 01~~4~~3 and 01~~5~~4. (~~3-30-01~~)(_____)

02. All basic hospital/medical-surgical expense policies and certificates shall display prominently on the first page of the policy or certificate in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a

basic hospital/medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (_____)

0176. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.

01. Minimum Standards for Benefits. The following minimum standards apply: (_____)

01a. Hospital Confinement Indemnity Coverage. A policy of accident and sickness insurance that pProvides daily benefits for hospital confinement on an indemnity basis in an amount not less than forty dollars ($40) per day; and not less than thirty-one (31) days during each period of confinement for each person insured under the policy. (3-30-01)(_____)

b. Provides benefits for not less than thirty-one (31) days during each period of confinement for each person insured under the policy. (3-30-01)(_____)

02. Preexisting Condition Limitation. Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded. (3-30-01)

03. No Coordination of Benefits. Benefits shall be paid regardless of other coverage. (3-30-01)

02. Prohibited Policy or Certificate Provisions. (_____)

a. Policies may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy or certificate, and the insurer demonstrates that the reserve basis for the policies is adequate. (_____)

b. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government. (_____)

03. Required Disclosure Provisions.

a. All hospital confinement indemnity policies and certificates shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a hospital confinement indemnity (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." (_____)

b. Outlines of coverage delivered in connection with "Hospital Confinement Indemnity Coverage" to persons eligible for Medicare by reason of age shall contain the following language in boldface type on the first page of the outline of coverage: "THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the 'Guide to Health Insurance for People with Medicare' available from the company." (_____)

018. INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE.

01. Major Medical Expense Coverage. Minimum Standards for Benefits. An accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than five hundred thousand dollars ($500,000); coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out of pocket maximum combined with any deductibles shall not exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person for at least: (3-30-01)

a. Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides; (3-30-01)

~~**b.** Miscellaneous hospital services; (3-30-01)~~

~~**c.** Surgical services; (3-30-01)~~

~~**d.** Anesthesia services; (3-30-01)~~

~~**e.** In-hospital medical services; and (3-30-01)~~

~~**f.** Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician. (3-30-01)~~

~~**02. Additional Benefits.** Individual major medical expense coverage must also provide not fewer than three (3) of the following additional benefits: (3-30-01)~~

~~**a.** In-hospital private duty registered nurse services; (3-30-01)~~

~~**b.** Convalescent nursing home care; (3-30-01)~~

~~**c.** Diagnosis and treatment by a radiologist or physiotherapist; (3-30-01)~~

~~**d.** Rental of special medical equipment, as defined by the insurer in the policy; (3-30-01)~~

~~**e.** Artificial limbs or eyes, casts, splints, trusses or braces; (3-30-01)~~

~~**f.** Treatment for functional nervous disorders, and mental and emotional disorders; or (3-30-01)~~

~~**g.** Out-of-hospital prescription drugs and medications. (3-30-01)~~

~~**03. Deductible Application.** If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage. (3-30-01)~~

~~**04. Benefit Requirements.** The minimum benefits required by Subsection 018.01 may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection 018.02 and other such special or internal limitations as are authorized or approved by the Director. Except as authorized by Subsection 018.04 through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to prior written approval by the Director or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum. (3-30-01)~~

019. DISABILITY INCOME PROTECTION COVERAGE.

~~A policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that: (3-30-01)~~

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

~~**01.** **Periodic Payments.**~~ **a.** Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62); ~~(3-30-01)~~( )

~~02~~**b.** ~~**Elimination Period.**~~ Contains an elimination period no greater than: (~~3-30-01~~)( )

~~a~~i. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less; (~~3-30-01~~)( )

~~b~~ii. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years; or (~~3-30-01~~)( )

~~c~~iii. Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury; (~~3-30-01~~)( )

c. Provides a maximum period of time for which benefits would be payable during disability of at least six (6) months; ( )

d. Defines partial disability no more restrictively that Subsection 010.21.; and ( )

e. Defines total disability no more restrictively than Subsection 010.29. ( )

~~**03. Payable Time Period During Disability.** Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period.~~ ~~(3-30-01)~~

~~**04. One Elimination Period.** Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required.~~ ~~(3-30-01)~~

02. Prohibited Policy Provisions. ( )

a. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required. ( )

b. A disability income policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate. ( )

c. Disability income benefits shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force. ( )

d. An individual or group supplemental policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed. ( )

e. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. ( )

f. No policy or certificate may use activities of daily living to define partial or total disability. ( )

03. Required Disclosure Provisions. All disability income protection policies shall display prominently on the first page of the policy, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following: "Notice to Buyer: This is a disability income protection policy." ( )

0~~20~~18. ACCIDENT ONLY COVERAGE.

~~A policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least one thousand dollars ($1000) and a single dismemberment amount shall be at least five hundred dollars ($500).~~ ~~(3-30-01)~~

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

a. Accidental death and double dismemberment amounts under the policy or certificate shall be at least one thousand dollars ($1000). ( )

b. A single dismemberment amount shall be at least five hundred dollars ($500). ( )

c. Benefits for disability, hospital or medical care shall be as defined in the policy or certificate. ( )

02. Prohibited Policy Provisions. Accident policies or certificates shall not contain probationary or waiting periods.

03. Required Disclosure Provisions. ( )

a. All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ( )

b. An accident-only policy or certificate providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy or certificate. ( )

c. Accident-only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer required by Paragraph 019.04.a.: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

021~~1~~9. SPECIFIED DISEASE COVERAGE.

01. ~~Specified Disease Coverage.~~ Minimum Standards for Benefits. ~~Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one (1) of the following sets of minimum standards for benefits, as defined in Section 021 for cancer only polices, or other specified disease coverage.~~ The following minimum standards apply: (~~3-30-01~~)( )

a. ~~Insurance covering~~ Coverage for cancer only or cancer in conjunction with other conditions or diseases must meet the standards of ~~Sections~~ Paragraphs ~~024, 025, or 027~~ 020.01.g, 020.01.h or 020.01.j.of this rule. (~~3-30-01~~)( )

b. ~~Insurance covering~~ Coverage for specified diseases other than cancer must meet the standards of ~~Sections 023 or 027~~ Paragraphs 020.01.e. or 020.01.j.of this rule. (~~3-30-01~~)( )

~~02~~c. ~~General Rules.~~ Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other requirements imposed by this rule. In cases of conflict ~~Subsections 021.02.a~~. Paragraphs 020.02.a. through ~~021.02.l.~~ 020.02.d. and Paragraphs 020.03.b through 020.03.e.

shall govern:. (3-30-01)( )

a. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under Section 021 of this rule. (3-30-01)

b. Any policy issued pursuant to Section 021 of this rule that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. (3-30-01)

c. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease. (3-30-01)

d. Individual accident and sickness policies containing specified disease coverage shall be guaranteed renewable. (3-30-01)

e. No policy issued pursuant to Section 021 shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person. (3-30-01)

f. An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not also covered by any Title XIX program (Medicaid, or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature. (3-30-01)

g. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. (3-30-01)

h. Benefits for specified disease coverage shall be paid regardless of other coverage. (3-30-01)

i. After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis. (3-30-01)

j. Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." (3-30-01)

k. Preexisting condition shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person." (3-30-01)

l. Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded. (3-30-01)

d. Hospice care is an optional benefit. If a specified disease insurance plan offers coverage for hospice care, it shall meet the following minimum standards: ( )

i. Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; ( )

ii. A fixed-sum payment of at least fifty dollars ($50) per day; and ( )

iii. A lifetime maximum benefit limit of at least ten thousand dollars ($10,000). (____)

e. Benefits for non-cancer coverage must provide coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars ($250) and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses: (____)

i. Hospital room and board and any other hospital furnished medical services or supplies; (____)

ii. Treatment by a legally qualified physician or surgeon; (____)

iii. Private duty services of a registered nurse (R.N.); (____)

iv. X-ray, radium and other therapy procedures used in diagnosis and treatment; (____)

v. Professional ambulance for local service to or from a local hospital; (____)

vi. Blood transfusions, including expense incurred for blood donors; (____)

vii. Drugs and medicines prescribed by a physician; (____)

viii. The rental of an iron lung or similar mechanical apparatus; (____)

ix. Braces, crutches, and wheel chairs deemed necessary by the attending physician for the treatment of the disease; (____)

x. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (____)

xi. May include coverage of any other expenses necessarily incurred in the treatment of the disease. (____)

f. Benefits for specifically named diseases must include: (____)

i. Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty five thousand dollars ($25,000) payable at the rate of not less than fifty dollars ($50) a day while confined in a hospital; and (____)

ii. A benefit period of at least Five hundred (500) days. (____)

g. Cancer only or combination polices must provide coverage for each insured person for cancer-only coverage or in combination with one (1) or more other specified diseases on an expense incurred basis for services, supplies, care, and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars ($250), and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than three (3) years shall provide at least the following minimum provisions: (____)

i. Treatment by, or under the direction of, a legally qualified physician or surgeon; (____)

ii. X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment; (____)

iii. Hospital room and board and any other hospital furnished medical services or supplies; (____)

iv. Blood transfusions and their administration, including expense incurred for blood donors; (____)

v. Drugs and medicines prescribed by a physician; (_____)

vi. Professional ambulance for local service to or from a local hospital**;** (_____)

vii. Private duty services of a registered nurse provided in a hospital; (_____)

viii. Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease; (_____)

ix. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (_____)

x. Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. Home health care includes, but is not limited to: (_____)

(1) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (_____)

(2) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech, or hearing occupational therapists; (_____)

(3) Physical, occupational, or speech and hearing therapy**;** (_____)

(4) Medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital; (_____)

(5) Therapy, including physical, speech, hearing, and occupational therapy; (_____)

(6) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances; (_____)

(7) Prosthetic devices including wigs and artificial breasts; (_____)

(8) Nursing home care for non-custodial services; and (_____)

(9) Reconstructive surgery when deemed necessary by the attending physician. (_____)

h. Per diem cancer coverage shall provide:

i. A fixed-sum payment of at least one hundred dollars ($100) for each day of hospital confinement for at least three hundred sixty-five (365) days; (_____)

ii. A fixed-sum payment equal to one-half (1/2) the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment; and (_____)

iii. A fixed-sum payment of at least fifty dollars ($50) per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least three hundred sixty-five (365) days of treatment. (_____)

i. Optional nursing home benefits shall provide: ( )

i. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days; ( )

ii. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of home health care for at least one hundred (100) days; and ( )

iii. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease. ( )

j. Lump sum indemnity coverage for specified disease shall provide: ( )

i. Dollar benefits shall be offered for sale only in increments of one thousand dollars ($1,000). The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease; and ( )

ii. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy or certificate clearly differentiates that subtype and its benefits. ( )

02. General Rules. ( )

a. Any coverage issued pursuant to this Section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. ( )

b. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease. ( )

c. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. ( )

d. After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis. ( )

03. Prohibited Policy or Certificate Provisions.

a. No specified disease coverage shall be offered for sale or issued as limited benefit coverage under Section 022. ( )

b. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this Section. ( )

c. No policy issued or reinstated pursuant to this Section shall contain a waiting period or probationary period greater than thirty (30) days. Benefits must be payable as of the thirty-first (31st) day of coverage or reinstatement, even if diagnosed during the waiting or probationary period. ( )

d. A specified disease policy or certificate may contain a waiting or probationary period following

the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person. If the policy or certificate meets the definition of an individual major medical expense coverage in Subsection 010.13, then this Paragraph does not apply.

e. Policies providing expense benefits shall not use the term "actual" when the policy or certificate only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." ( )

f. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in Subparagraphs 020.01.i.i and 020.01.i.ii., whether by definition or otherwise, shall be no more restrictive than those under Medicare. ( )

g. Hospice care does not cover non-terminally ill patients who may be confined in a: ( )

i. Convalescent home; ( )

ii. Rest or nursing facility; ( )

iii. Skilled nursing facility**;** ( )

iv. Rehabilitation unit; or ( )

v. Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers. ( )

04. Required Disclosure Provisions. ( )

a. An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not also covered by any Title XIX program (Medicaid, or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature. ( )

b. All specified disease policies and certificates shall contain on the first page in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate a prominent statement as follows: "Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage." ( )

c. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

020. SPECIFIED ACCIDENT COVERAGE. ( )

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

a. Provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy or certificate for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars ($1,000) for accidental death. ( )

b. A benefit amount not less than one thousand dollars ($1,000) for double dismemberment. ( )

c. A benefit amount not less than five hundred dollars ($500) for single dismemberment. ( )

02. Prohibited Policy or Certificate Provisions. Accident policies shall not contain probationary or waiting periods. ( )

03. Required Disclosure Provisions. ( )

a. Accident-only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer required by Paragraph 021.03.b.: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

b. All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ( )

~~**022. HOSPICE CARE.**~~

~~**01. Hospice Care**. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (3-30-01)~~

~~**a.** For terminally ill patients whose life expectancy is less than six (6) months; (3-30-01)~~

~~**b.** Provided on an inpatient or outpatient basis; and (3-30-01)~~

~~**c.** Directed by a physician. (3-30-01)~~

~~**02. Optional Benefit**. Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: (3-30-01)~~

~~**a.** Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; (3-30-01)~~

~~**b.** A fixed sum payment of at least fifty dollars ($50) per day; and (3-30-01)~~

~~**c.** A lifetime maximum benefit limit of at least ten thousand dollars ($10,000). (3-30-01)~~

~~**03. Non-Terminally Ill Patients**. Hospice care does not cover non-terminally ill patients who may be confined in a: (3-30-01)~~

~~**a.** Convalescent home; (3-30-01)~~

~~**b.** Rest or nursing facility; (3-30-01)~~

~~**c.** Skilled nursing facility; (3-30-01)~~

~~**d.** Rehabilitation unit; or (3-30-01)~~

~~**e.** Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers. (3-30-01)~~

021. LIMITED BENFIT COVERAGE. ( )

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

a. Coverage must be marketed solely as supplemental health insurance and not as a substitute for individual major medical expense coverage. ( )

b. Policies or contracts may be offered, delivered issued for delivery, continued or renewed in this state only if the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by paragraph 101.01.a. ( )

02. Required Disclosure Provisions. ( )

a. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

b. All limited benefit health policies and certificates shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to buyer: This is a limited benefit health (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." ( )

~~**023. NON-CANCER COVERAGES.**~~
~~The following minimum benefits standards apply to non-cancer coverages: (3-30-01)~~

~~**01. Minimum Benefit Standards for Non-Cancer Coverages.** Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars ($250) and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses: (3-30-01)~~

~~**a.** Hospital room and board and any other hospital furnished medical services or supplies; (3-30-01)~~

~~**b.** Treatment by a legally qualified physician or surgeon; (3-30-01)~~

~~**c.** Private duty services of a registered nurse (R.N.); (3-30-01)~~

~~**d.** X-ray, radium and other therapy procedures used in diagnosis and treatment; (3-30-01)~~

~~**e.** Professional ambulance for local service to or from a local hospital; (3-30-01)~~

~~**f.** Blood transfusions, including expense incurred for blood donors; (3-30-01)~~

~~**g.** Drugs and medicines prescribed by a physician; (3-30-01)~~

~~**h.** The rental of an iron lung or similar mechanical apparatus; (3-30-01)~~

~~**i.** Braces, crutches, and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; (3-30-01)~~

~~**j.** Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (3-30-01)~~

~~**k.** May include coverage of any other expenses necessarily incurred in the treatment of the disease. (3-30-01)~~

~~**02. Benefit Limits for Specifically Named Disease.** Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty-five thousand dollars ($25,000) payable at the rate of not less than fifty dollars ($50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days. (3-30-01)~~

022. SHORT TERM COVERAGE. ( )

01. Minimum Standards for Benefits. The following minimum standards apply: ( )

a. Short term coverage must be issued for a period of twelve (12) months or less. ( )

b. Short term coverage that provides hospital, medical-surgical coverage shall not be marketed as a substitute for an individual major medical expense coverage. ( )

c. Short term plans must be nonrenewable. ( )

02. Prohibited Policy or Certificate Provisions. Short term coverage may not be marketed to federally eligible individuals, as defined by HIPAA, without disclosure of the preexisting condition exclusions applicable to the coverage. ( )

03. Required Disclosure Provisions. ( )

a. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." ( )

b. All short term policies and certificates shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a nonrenewable short term (policy) (certificate). This (policy) (certificate) provides benefits for a limited period and should not be considered a substitute for renewable major medical expense coverage." ( )

~~**024. CANCER ONLY OR COMBINATION POLICIES.**~~

~~A policy that provides coverage for each insured person for cancer only coverage or in combination with one (1) or more other specified diseases on an expense incurred basis for services, supplies, care, and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars ($250), and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than three (3) years shall provide at least the following minimum provisions: (3-30-01)~~

~~**01. Qualified Physician or Surgeon.** Treatment by, or under the direction of, a legally qualified physician or surgeon; (3-30-01)~~

~~**02. X-Ray and Therapy Procedures.** X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment; (3-30-01)~~

~~**03. Hospital.** Hospital room and board and any other hospital furnished medical services or supplies; (3-30-01)~~

~~**04. Blood Transfusions.** Blood transfusions and their administration, including expense incurred for blood donors; (3-30-01)~~

~~**05. Prescription Medicines.** Drugs and medicines prescribed by a physician; (3-30-01)~~

~~**06. Ambulance Services.** Professional ambulance for local service to or from a local hospital; (3-30-01)~~

~~**07. Private Duty Nurse.** Private duty services of a registered nurse provided in a hospital; (3-30-01)~~

~~**08. Medical Equipment.** Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease; (3-30-01)~~

~~09. **Emergency Transportation to Referral Treatment Facility**. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (3-30-01)~~

~~10. **Home Health Care and Treatment**. Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" is an agency approved under Medicare, or is licensed to provide home health care under applicable state law, or meets all of the following requirements:(3-30-01)~~

~~a. It is primarily engaged in providing home health care services; (3-30-01)~~

~~b. Its policies are established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse); (3-30-01)~~

~~c. A physician or a registered nurse provides supervision of home health care services; (3-30-01)~~

~~d. It maintains clinical records on all patients; and (3-30-01)~~

~~e. It has a full time administrator. (3-30-01)~~

~~11. **Home Health Care**. Home health care includes, but is not limited to: (3-30-01)~~

~~a. Part time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (3-30-01)~~

~~b. Part time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech, or hearing occupational therapists; (3-30-01)~~

~~c. Physical, occupational, or speech and hearing therapy; and (3-30-01)~~

~~d. Medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital. (3-30-01)~~

~~12. **Therapy**. Therapy includes physical, speech, hearing, and occupational therapy; (3-30-01)~~

~~13. **Special Equipment**. Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances; (3-30-01)~~

~~14. **Prosthetic Devices**. Prosthetic devices including wigs and artificial breasts; (3-30-01)~~

~~15. **Non-Custodial Services**. Nursing home care for non-custodial services; and (3-30-01)~~

~~16. **Reconstructive Surgery**. Reconstructive surgery when deemed necessary by the attending physician. (3-30-01)~~

023. DENTAL COVERAGE. (____)

01. Required Disclosure Provisions. Dental coverage must include the following disclosures;(____)

a. All applications shall contain a prominent statement in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction

with the applicant's signature block on the application as follows: "The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate) carefully." ( )

b. All dental plan policies and certificates shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides dental benefits only." ( )

~~**025. PER DIEM CANCER COVERAGES.**~~

~~The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (3-30-01)~~

~~**01. Minimum Benefit Payment Based on Hospital Confinement**. A fixed sum payment of at least one hundred dollars ($100) for each day of hospital confinement for at least three hundred sixty-five (365) days; (3-30-01)~~

~~**02. Minimum Benefit Payment Based on Out-Patient Services**. A fixed sum payment equal to one-half (1/2) the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment; and (3-30-01)~~

~~**03. Minimum Benefit Payment Based on Administration of Plasma or Blood Donor**. A fixed sum payment of at least fifty dollars ($50) per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least three hundred sixty-five (365) days of treatment. (3-30-01)~~

024. VISION COVERAGE. ( )

01. Required Disclosure Provisions. Vision coverage must include the following disclosures;( )

a. All applications shall contain a prominent statement in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully." ( )

b. All vision plan policies and certificates shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides vision benefits only." ( )

~~**026. NURSING HOME BENEFITS.**~~

~~Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following: (3-30-01)~~

~~**01. Minimum Benefit Standards Based on Nursing Home Confinement**. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days. (3-30-01)~~

~~**02. Minimum Benefit Standards Based on Home Health Care**. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of home health care for at least one hundred (100) days. (3-30-01)~~

~~**03. Benefit Payments**. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease. (3-30-01)~~

~~**04. Restrictions or Limitations**. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in Subsections 026.01. and 026.02. of this rule, whether by definition or otherwise, shall be no more restrictive than those under Medicare. (3-30-01)~~

~~**027. LUMP SUM INDEMNITY COVERAGE.**~~
~~The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease: (3-30-01)~~

~~**01. Indemnity Benefit, Specific Disease**. These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of one thousand dollars ($1,000). (3-30-01)~~

~~**02. Equal Coverage**. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits. (3-30-01)~~

~~**028. SPECIFIED ACCIDENT COVERAGE.**~~
~~A policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars ($1,000) for double dismemberment and five hundred dollars ($500) for single dismemberment. (3-30-01)~~

~~**029. LIMITED BENEFIT HEALTH COVERAGE.**~~

~~**01. Limited Benefit Plan**. A policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Sections 014, 015 through 018, 020, and 028 of this rule. Limited Benefit Health Coverage policies or contracts may be delivered or issued for delivery in this state only if an outline of coverage meeting the requirements of this rule for "Limited Benefit Health Coverage" is completed and delivered as required by Subsection 101.01.n. of this rule and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Subsection 101.01.a. A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 021 of this rule, and shall not be offered for sale as a "limited coverage." (3-30-01)~~

~~**02. Limited Benefit Plan Exceptions**. Subsection 029.02 does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in Chapter 46, Title 41, Idaho Code, "Long-Term Care Insurance" and Chapter 44, Title 41, Idaho Code, "Medicare Supplement Insurance Minimum Standards." (3-30-01)~~

0~~30~~26. -- 100. (RESERVED)

101. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules for Disclosure Provisions. (~~3-30-01~~)(_____)

a. All applications for coverages specified in Sections 0~~14~~3 through 01~~8~~6, 0~~20~~18, 02~~8~~0, and 02~~9~~1 of this rule shall contain a prominent statement ~~by type, stamp or other appropriate means~~ in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully." (~~3-30-01~~)(_____)

~~**b.** All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate)~~

~~carefully." (3-30-01)~~

~~c. All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully." (3-30-01)~~

~~d~~**b.** Each policy ~~of individual accident and sickness insurance and group supplemental health insurance~~ or certificate subject to this rule shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy or certificate, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. (~~3-30-01~~)(_____)

~~e~~**c.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium. (~~3-30-01~~)(_____)

~~f~~**d.** Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate. (~~3-30-01~~)(_____)

~~g~~**e.** A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage consistent with Subsection 010.30.
. (~~3-30-01~~)(_____)

~~h~~**f.** If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations." (~~3-30-01~~)(_____)

~~i. All accident only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." (3-30-01)~~

~~j. Accident only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer required by Subsection 101.01.i.: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." (3-30-01)~~

~~k~~**g.** All policies and certificates~~, except single-premium nonrenewable policies and as otherwise provided in this paragraph,~~ shall have a notice prominently printed on the first page of the policy or certificate ~~or attached to it~~ stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. (~~3-30-01~~)(_____)

~~l~~**h.** If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage. (~~3-30-01~~)(_____)

~~m~~**i.** If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: (~~3-30-01~~)(_____)

i. The caption of the provision shall be "Conversion Privilege" or words of similar import~~.~~; (~~3-30-01~~)(_____)

ii. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised~~.~~; and (~~3-30-01~~)(_____)

iii. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose. (3-30-01)

~~**n.** Outlines of coverage delivered in connection with policies defined as "Hospital Confinement Indemnity Coverage" in Section 017, "Specified Disease Coverage" in Subsection 012.09, or "Limited Benefit Health Coverage" in Section 029 of this rule to persons eligible for Medicare by reason of age shall contain the information for hospital confinement indemnity providing limited benefits (supplemental benefits) and Accident Only Coverage as set forth in the model outlines of coverage found on the Department of Insurance Internet web site at www.doi.state.id.us, "Consumer Assistance" link. In addition, the following language shall be printed on or attached to the first page of the outline of coverage: "THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the 'Guide to Health Insurance for People With Medicare' available from the company." (3-30-01)~~

~~i. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.01.54, Section 019, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." (3-30-01)~~

~~**o.** All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate a prominent statement as follows: "Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage." (3-30-01)~~

~~**p.** All hospital confinement indemnity policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a hospital confinement indemnity (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." (3-30-01)~~

~~**q.** All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a limited benefit health (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses." (3-30-01)~~

~~**r.** All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a basic hospital expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (3-30-01)~~

~~**s.** All basic medical surgical expense policies and certificates shall display prominently by type,~~

~~stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a basic medical surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (3-30-01)~~

~~**t.** All basic hospital/medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This is a basic hospital/medical surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage." (3-30-01)~~

~~**u.** All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides dental benefits only." (3-30-01)~~

~~**v.** All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: "Notice to Buyer: This (policy) (certificate) provides vision benefits only." (3-30-01)~~

02. Outline of Coverage Requirements. Outlines of coverage required under this rule will conform to the model outlines of coverage ~~as~~ incorporated herein in Section 004. and set forth at the Idaho Department of Insurance web-site, ~~www.doi.state.id.us, under the consumer assistance link~~www.doi.idaho.gov. (~~3-30-01~~)(____)

a. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans as required by Section 41-4205, Idaho Code~~, that conforms to Subsection 013.03 of this rule~~. If an application is made by electronic means, an insurer must deliver an outline of coverage on the same day as the application is taken, and delivery may be made by the following methods regardless of the form of application: (~~3-30-01~~)(____)

i. E-mail; (____)

ii. Website link; (____)

iii. Facsimile; (____)

iv. First class mail; or (____)

v. Any other method permitted by the Director. (____)

b. If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point boldface type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon (application) (enrollment), and the coverage originally applied for has not been issued."** (~~3-30-01~~)(____)

~~**c.** The appropriate outline of coverage for policies or contracts providing hospital coverage that only meet the standards of Section 014 shall be that statement contained in the model outline of coverage for Basic Hospital Expense Coverage, as set forth at the Department of Insurance Internet website, www.doi.state.id.us. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 014 and 015, shall be the statement contained in the model outline of coverage for Basic Hospital/Medical Surgical Expense Coverage, as set forth at the Department web site. The appropriate outline of coverage for policies providing~~

~~coverage that meets the standards of both Sections 014 and 017, or Sections 016 and 017, or Sections 014, 015, and 017 shall be the statement contained in the model outline of coverage for Individual Major Medical Expense Coverage as set forth at the Department web site. (3-30-01)~~

~~d~~c. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be ~~submitted to~~ filed with the Director ~~for prior written approval~~. (~~3-30-01~~)(____)

102. -- 200. (RESERVED)

201. REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE.

01. Application Form. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used. (3-30-01)

02. Required Notice. Upon determining that a sale will involve replacement, an insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance," taking into consideration the requirement for direct response or other than direct response. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in ~~Section 201~~this Subsection. (~~3-30-01~~)(____)

a. The required notice for a direct response insurer shall use the format shown in Appendix A. (____)

b. The required notice for other than a direct response insurer shall use the format shown in Appendix B. (____)

202. -- 999. (RESERVED)