# ACCIDENT & HEALTH OR SICKNESS

General Outline: Product Knowledge, Terms, and Concepts
(50 scored plus 5 pretest questions)

**I. TYPES OF POLICIES .....**

A. Disability income
  1. Individual disability income policy
  2. Business overhead expense policy
  3. Business disability buyout policy
  4. Group disability income policy
  5. Key employee policy

B. Accidental death and dismemberment

C. Medical expense insurance
  1. Basic hospital, medical, and surgical policies
  2. Major medical policies
  3. Health Maintenance Organizations (HMOs)
  4. Preferred Provider Organizations (PPOs)
  5. Point of Service (POS) plans
  6. Flexible Spending Accounts (FSAs)
  7. High Deductible Health Plans (HDHPs) and related Health Savings Accounts (HSAs)
  8. Health Reimbursement Accounts (HRAs)

D. Medicare supplement policies

E. Group insurance
  1. Differences between individual and group contracts
  2. General characteristics
  3. COBRA

F. Individual/Group Long Term Care (LTC)
  1. Eligibility
  2. Levels of care

G. Other policies
  1. Dental
  2. Vision
  3. Cancer
  4. Critical illness or specified disease
  5. Worksite (employer-sponsored)
  6. Hospital indemnity
  7. Short-term medical
  8. Accident

**II. POLICY PROVISIONS, CLAUSES, AND RIDERS .....**

A. Mandatory and optional provisions
  1. Entire contract
  2. Time limit on certain defenses (incontestable)
  3. Grace period
  4. Reinstatement
  5. Notice of claim
  6. Claim forms
  7. Proof of loss
  8. Time of payment of claims
  9. Payment of claims
  10. Physical examination and autopsy
  11. Legal actions
  12. Change of beneficiary
  13. Misstatement of age or gender
  14. Change of occupation
  15. Illegal occupation
  16. Relation of earnings to insurance

B. Other provisions and clauses
  1. Insuring clause
  2. Free look
  3. Consideration clause
  4. Probationary period
  5. Elimination period
  6. Waiver of premium
  7. Exclusions and limitations
  8. Preexisting conditions
  9. Coinsurance
  10. Deductibles

***II. POLICY PROVISIONS, CLAUSES, AND RIDERS (continued)***

  11. Eligible expenses
  12. Copayments
  13. Pre-authorizations and prior approval requirements
  14. Usual, reasonable, and customary (URC) charges
  15. Lifetime, annual, or per cause maximum benefit limits

C. Riders
  1. Impairment/exclusions
  2. Guaranteed insurability
  3. Future increase option

D. Rights of renewability
  1. Noncancelable
  2. Cancelable
  3. Guaranteed renewable

**III. SOCIAL INSURANCE .....**

A. Medicare (Parts A, B, C, D)

B. Medicaid

C. Social Security benefits

**IV. OTHER INSURANCE CONCEPTS .....**

A. Total, partial, recurrent and residual disability

B. Owner's rights

C. Dependent children benefits

D. Primary and contingent beneficiaries

E. Modes of premium payments

F. Nonduplication and coordination of benefits (e.g., primary vs. excess)

G. Occupational vs. non-occupational

H. Tax treatment of premiums and proceeds of insurance contracts (e.g., disability income and medical expenses, etc.)

I. Managed care

J. Workers Compensation
  1. Impact on health insurance benefits

K. Subrogation

L. Cost containment

**V. FIELD UNDERWRITING PROCEDURES .....**

A. Completing the application

B. Explaining sources of insurability and HIPAA privacy information (e.g., MIB Report, Fair Credit Reporting Act, etc.)

C. Initial premium payment and receipt and consequences of the receipt (e.g., medical examination, etc.)

D. Submitting application (and initial premium if collected) to company for underwriting

E. Policy delivery

F. Explaining policy and its provisions, riders, exclusions, and ratings to clients

G. Replacement

H. Contract law
  1. Elements of a contract
  2. Insurable interest
  3. Warranties and representations
  4. Unique aspects of the insurance contract
    a. Conditional
    b. Unilateral
    c. Adhesion
    d. Aleatory

# Accident & Health or Sickness

Idaho State Laws, Rules, and Regulations *(25 scored plus 6 pretest questions)*
Ref: All references are to Idaho Insurance Laws Title 41 unless otherwise noted

**I. IDAHO STATUTES, RULES, AND REGULATIONS COMMON TO LIFE, HEALTH/DISABILITY, PROPERTY, CASUALTY, AND PERSONAL LINES INSURANCE……...**

A. Responsibilities of the Director of the Department of Insurance: *Ref: 41-203*
  1. Appointment: *Ref: 41-202*
  2. General duties and powers: *Ref: 41-211, 41-213, 41-247, 41-1016*
  3. Examinations: *Ref: 41-210, 41-219, 41-220*
  4. Hearings/notice of hearings/orders: *Ref: 41-212, 41-232, 41-235, 41-1321*
  5. Penalties: *Ref: 41-117, 41-117A, 41-1016*

B. Definitions
  1. Domestic company: *Ref: 41-106(1)*
  2. Foreign company: *Ref: 41-106(2)*
  3. Alien company: *Ref: 41-106(3)*
  4. Fraternals: *Ref: 41-3201, 41- 3210*
  5. Authorized and unauthorized companies/admitted and nonadmitted companies: *Ref: 41-110*
  6. Stock and mutual companies and reciprocals: *Ref: 41-301,41-302, 41-2902*
  7. Certificate of authority: *Ref: 41-111, 41-305, 41-306*
  8. Transacting insurance: *Ref: 41-112*
  9. Negotiate: *Ref: 41-1003(6)*

C. Licensing
  1. Persons required to be licensed
    a. Producer: *Ref: 41-1003(8), 41-1004, 41-1008, 41-1018*
    b. Resident/nonresident: *Ref: 41-1003(9), 41- 1009, 41-1010*
  2. Producer appointment/termination of appointment: *Ref: 41-1011, 41-1018, 41-1019, 41-1103*
  3. Obtaining a license
    a. Qualifications: *Ref: 41-1007, 41-1104*
    b. License application: *Ref: 41-1006, 41-1007, 41-1016*
    c. Written examinations: *Ref: 41-1006*
    d. Exemptions/exceptions: *Ref: 41-1005, 41-1007(4), 41-1012*
    e. License denial/refusal: *Ref: 41-1011, 41-1016*
  4. Maintaining a license
    a. Continuing education: *Ref: 41-1013, IDAPA 18.06.04*
    b. Change of address/place of business: *Ref: 41-1008(6), 41-1009(3)*
    c. Fees/renewal: *Ref: 41-1008, IDAPA 18.01.02*
    d. Record keeping: *Ref: 41-1036*
    e. License expiration: *Ref: 41-1013*
    f. Suspension or revocation of licenses/felony convictions: *Ref: 41-1016, 41-1026*

D. Producer responsibilities
  1. Fiduciary capacity: *Ref: 41-1024, 41-1323, 41-1325, 41-1803, IDAPA 18.06.02*
  2. Commissions and compensation: *Ref: 41-1017, 41-1323*
  3. Charging of fees and disclosure requirements: *Ref: 41-1030; IDAPA 18.06.02*
  4. Reporting of actions: *Ref: 41-1021*

E. Insurance contracts
  1. Filing and approval of policy forms: *Ref: 41-1812*
  2. Payment of claims: *Ref: 41-1328, 41-1828*
  3. Power to contract: *Ref: 41-1807*

F. Marketing practices
  1. Unfair claims practices: *Ref: 41-258, 41-1328, 41-1329, 41-1839, 41-3611*
  2. Unfair methods of competition
    a. Rebating: *Ref: 41-1314*
    b. Misrepresentation: *Ref: 41-1303*
    c. False advertising: *Ref: 41-1303, 41-1304*
    d. Defamation: *Ref: 41-1308*
    e. False financial statements: *Ref: 41-1306*
    f. Boycott, coercion, intimidation: *Ref: 41-1309*
    g. Unfair discrimination: *Ref: 41-1313, 41-1315*
    h. Coercion of borrower: *Ref: 41-1310 to 41-1312*
    i. Fraud: *Ref: 41-290, 41-293; Bulletin 03-08*
    j. Twisting: *Ref: 41-*1305
  3. Penalties: *Ref: 41-117, 41-1016, 41-1327, 41-1329A*

**II. IDAHO STATUTES, RULES, AND REGULATIONS COMMON TO LIFE AND HEALTH/ DISABILITY INSURANCE ONLY……**

A. Credit life and disability insurance: *Ref: 41-2303 to 41-2305, 41- 2307, 41-2311, IDAPA 18.03.05*
B. Life and Health Insurance Guaranty Association Act: *Ref: 41-4301 to 41-4310*
C. Assignment: *Ref: 41-1826, 41-1828, 41-2025*

**III. IDAHO STATUTES, RULES, AND REGULATIONS PERTINENT TO HEALTH/DISABILITY INSURANCE ONLY…….**

A. Policy clauses and provisions
  1. Minimum standards
    a. Purpose: *Ref: 41-4201, IDAPA 18.04.03*
    b. Definition: *Ref: 41-2212, 41- 4202, 41-4703, 41-520; IDAPA 18.04.08*
  2. Required and optional coverages: *Ref: PPACA*
    a. Newborns and adopted children: *Ref: 41-2140, 41-2210,41-3932, 41-2103(3), 41-4703(11), 41-5501(4)*
    b. Maternity benefits: *Ref: 41-2140, 41-2210, 41-3438, 41-3932, 41-4023*
    c. Handicapped dependents: *Ref: 41-2139, IDAPA 18.04.08*
    d. Reconstructive surgery/prosthetic devices: *Ref: IDAPA 18.04.08*
    e. Free look: *Ref: 41-2138*
    f. Right of insurer to contest (time limit on certain defenses): *Ref: 41-2106*
    g. Grace period: *Ref: 41-2107*
    h. Pre-existing conditions: *Ref: 41-2221, 41-4206, 41-5208*
    i. Skilled nursing facility: *Ref: IDAPA 18.04.08*
    j. Mammograms: *Ref: 41-2144, 41-2218, 41-3926*
  3. Benefit standards: *Ref: IDAPA 18.04.08*

B. Accidental death and dismemberment IDAHO – Insurance Examination Content Outlines *Effective: September 1, 2023* S6: *Ref: 41-501, 41-502; IDAPA 18.04.08*

C. Disclosure
  1. Outline of coverage: *Ref: 41-4203 to 41-4205; IDAPA 18.04.08*
  2. Renewal agreements/nonrenewal and cancellation: *Ref: 41-2107 to 41-2108, 41-4707, 41-5207; IDAPA 18.04.08*

D. Medicare supplement insurance: *Ref: 41-4402, 41-4403, 41-4406 to 41-4408, IDAPA 18.04.10*

E. Long term care
  1. Definitions: *Ref. 41-4603, IDAPA 18.04.11*
  2. Disclosure Statements: *Ref: 41-4605, IDAPA 18.04.11*
  3. Activities of Daily Living: *Ref: IDAPA 18.04.11*
  4. Producer Training Requirement: *Ref: IDAPA 18.04.11*
  5. Suitability: *Ref: IDAPA 18.04.11*

F. Small employer health insurance availability act: *Ref: Title 41-Chapter 47*
  1. Special provisions
  2. Disclosure requirements
  3. Termination/nonrenewal
  4. Fair marketing standards
  5. Definitions
    a. Small employer Ref: 14-4703, *41-*4708
    b. Eligible employee Ref: 41-4703

G. Individual health insurance availability act: *Ref: Title 41-Chapter 52*
H. Disability income protection: *Ref: 41-1008, 41-4204; IDAPA 18.04.08*
I. Idaho Health Carrier External Review Act: *Ref: 41-5901 to 41-5917; 18.01.05*

G. Individual health insurance availability act: *Ref: Title 41-Chapter 52*
H. Disability income protection: *Ref: 41-1008, 41-4204; IDAPA 18.04.08*
I. Idaho Health Carrier External Review Act: *Ref: 41-5901 to 41-5917; 18.01.05*

# IDAHO SPECIFIC CONTENT OUTLINE: ACCIDENT, HEALTH OR SICKNESS
## State Laws, Rules, and Regulations

**14-4703: Editing error please see 41-4703**

**14-4708: Editing error please see 41-4708**

**41-106. "DOMESTIC," "FOREIGN," "ALIEN" INSURER DEFINED.**
(1) A "domestic" insurer is one formed under the laws of this state or an insurer which has transferred its domicile pursuant to section 41-342, Idaho Code, to this state.
(2) A "foreign" insurer is one formed under the laws of a jurisdiction other than this state.
(3) An "alien" insurer is one formed under the laws of any country other than the United States of America, its states, districts, territories, and commonwealths.
(4) Except where distinguished by context, "foreign" insurers includes also "alien" insurers.

**41-110. "AUTHORIZED," "UNAUTHORIZED" INSURER DEFINED.**
(1) An "authorized" insurer is one duly authorized by a subsisting certificate of authority issued by the director to transact insurance in this state.
(2) An "unauthorized" insurer is one not so authorized.

**41-111. "CERTIFICATE OF AUTHORITY," "LICENSE" DEFINED.**
(1) A "certificate of authority" is one issued by the director evidencing the authority of an insurer to transact insurance in this state.
(2) A "license" is authority granted by the director pursuant to this code authorizing the licensee to engage in a business or operation of insurance in this state other than as an insurer, and the certificate by which such authority is evidenced.

**41-112. "TRANSACTING INSURANCE" DEFINED.** "Transacting insurance" includes any of the following:
(1) Solicitation and inducement.
(2) Preliminary negotiations.
(3) Effectuation of a contract of insurance.
(4) Transaction of matters subsequent to effectuation of a contract of insurance and arising out of it.
(5) Mailing or otherwise delivering any written solicitation to any person in this state by an insurer or any person acting on behalf of the insurer for fee or compensation.

**41-117. GENERAL PENALTY.**
Each violation of this code for which a greater penalty is not provided by another provision of this code or by other applicable laws of this state, shall in addition to any applicable prescribed denial, suspension, or revocation of certificate of authority or license be punishable by an administrative penalty of not more than one thousand dollars ($1,000) for any individual or natural person and not more than five thousand dollars ($5,000) for any other person, imposed by the director, and upon conviction by a fine of not more than one thousand dollars ($1,000) or by imprisonment in the county jail for a period not to exceed six (6) months, or by both such fine and imprisonment in the discretion of the court. Each instance of violation may be considered a separate offense.

**41-117A. PENALTY FOR TRANSACTING INSURANCE WITHOUT PROPER LICENSING.**
The director may impose an administrative penalty not to exceed fifteen thousand dollars ($15,000), for deposit in the general account of the state of Idaho, upon any person who transacts insurance of any kind or character or transmits for a person, other than himself, an application for a policy of insurance without proper licensing, or after such licensing shall have been suspended or revoked.

**41-202. DIRECTOR — APPOINTMENT — TERM — QUALIFICATIONS.**
(1) The director of the department of insurance shall be the chief executive officer of the department of insurance.
(2) The director shall be appointed by the governor and shall hold office for a term of four (4) years, subject to earlier removal by the governor. A vacancy in the office of director shall be filled for the balance of the unexpired term only.
(3) The governor shall not appoint as director any individual, and no individual shall hold the office of director, who is not qualified therefor as follows:
    (a) Must be a qualified elector of the state of Idaho; and
    (b) Must have had at least five (5) years' practical experience in one or more of the types of insurance business subject to regulation by the director, or have had other professional or business experience reasonably adequate in character and scope to equip him to discharge the duties and fulfill the responsibilities of the office of director.

**41-203. TERMS CONSTRUED.**
Wherever the words "commissioner of insurance" or "insurance commissioner" appear in title 41, Idaho Code, or elsewhere in the Idaho Code, they shall be understood and construed to mean the director of the department of insurance.

**41-210. GENERAL POWERS, DUTIES.**
(1) The director shall enforce the provisions of this code, and shall execute the duties imposed upon him by this code.
(2) The director shall have the powers and authority expressly conferred upon him by or reasonably implied from the provisions of this code.
(3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he may deem proper to determine whether any person has violated any provision of this code or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.
(4) For any document required to be filed with the director or the department of insurance under the laws of this state, the director may specify the place and manner of filing of the document, including whether an electronic or paper filing is required or acceptable.
(5) The director shall have such additional powers and duties as may be provided by other laws of this state.

**41-211. RULES.**
(1) The director may make reasonable rules necessary for or as an aid to the effectuation of any provision of this code. No such rule shall extend, modify, or conflict with any law of this state or the reasonable implications thereof.
(2) Any such rule affecting persons or matters other than the personnel or the internal affairs of the department shall be made or amended in accordance with the provisions of chapter 52, title 67, Idaho Code.
(3) In addition to any other penalty provided, wilful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

**41-212. ORDERS, NOTICES.**

(1) Orders and notices of the director shall be effective only when in writing signed by him or by his authority.

(2) Every such order shall state its effective date, and shall concisely state:

(a) Its intent or purpose.

(b) The grounds on which based.

(c) The provisions of this code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the director of the right to rely thereon.

(3) Except as may be provided in this code respecting particular procedures, an order or notice may be given by:

(a) Personal service upon the person to be ordered or notified;

(b) Mailing it, postage prepaid, by regular United States mail, or by certified mail, return receipt requested, addressed to the person at his residence or principal place of business as last of record in the department; or

(c) Where a party has appeared in a contested case or has not yet appeared but has consented or agreed in writing to service by facsimile transmission (FAX) or e-mail as an alternative to personal service or service by mail, such orders or notices may be served by FAX or by e-mail in lieu of service by mail or personal service.

(4) Service of orders and notices is complete when a copy is personally served upon the person to be served, or when a copy properly addressed and postage prepaid is deposited in the United States mail or the statehouse mail, if the person is a state employee or state agency, or when there is an electronic verification that a FAX or an e-mail has been sent.

**41-213. ENFORCEMENT.**

(1) The director may institute such suits or other lawful proceedings as he may deem necessary for the enforcement of any provision of title 41, Idaho Code. If the director believes that any person has engaged in or is about to engage in any act or practice constituting a violation of any provision of title 41, Idaho Code, any other law the director has authority to enforce, or any rule or order of the director, the director may, in accordance with the procedures set forth in title 41, Idaho Code, and chapter 52, title 67, Idaho Code:

(a) Issue an order requiring the person to cease and desist from any prohibited act or practice;

(b) Issue an order affecting a person's license for such reasons as set forth in title 41, Idaho Code;

(c) Issue an order imposing an administrative penalty as provided in title 41, Idaho Code; and

(d) Initiate any action in district court for the same relief or any relief authorized by title 41, Idaho Code.

(2) If the director believes that any person is violating or about to violate any provision of title 41, Idaho Code, or any order or requirement of the director issued or promulgated pursuant to authority expressly granted the director by any provision of title 41, Idaho Code, or by other law, the director may bring an action against such person in the name of the people of the state of Idaho in a district court of this state to enjoin such person from continuing such violation or doing any act in furtherance thereof. In the action the court may enter such order or judgment granting such preliminary or final injunction as the court determines to be proper.

(3) If the director has reason to believe that any person has violated any provision of title 41, Idaho Code, or any provision of other law as applicable to insurance operations, for which criminal prosecution is provided and would be in order, he shall give the information relative thereto to the attorney general or county attorney having jurisdiction of any such violation. The attorney general or county attorney shall promptly institute such action or proceedings against such person as the information may require or justify.

(4) Whenever the director may deem it necessary, he shall employ counsel, or call upon the attorney general of this state for legal counsel and such assistance as may be necessary.

**41-219. EXAMINATION OF INSURERS.**

(1) For the purpose of determining its financial condition, ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, and compliance with the law, the director shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer, including the attorney in fact of a reciprocal insurer in so far as insurer transactions are concerned, as often as he deems advisable. The director or any of the director's examiners may conduct an examination, in accordance with the provisions of this section, of any company as often as the director in his sole discretion deems appropriate but shall, at a minimum, conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the director shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiners' handbook adopted by the national association of insurance commissioners and in effect when the director exercises discretion under the provisions of this section.

(2) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the director.

(3) The director shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this state.

(4) In lieu of an examination under the provisions of this section, of any foreign or alien insurer licensed in this state, the director may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port of entry until January 1, 1994. Thereafter, such reports may only be accepted if the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program or, the examination is performed under the supervision of an accredited insurance department or with participation of one (1) or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(5) The term "company" as used in this section shall mean any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the director.

**41-220. EXAMINATION OF AGENTS, BROKERS, CONSULTANTS, MANAGERS, ADJUSTERS, PROMOTERS.**

(1) For the purpose of ascertaining compliance with law, and in addition to any right of examination otherwise provided, the director may as often as he deems advisable examine the accounts, records, documents, and transactions, pertaining to or affecting its insurance affairs or proposed insurance affairs, of: (1) any insurance agent, broker, solicitor, consultant, surplus line broker, general agent, or adjuster.

(2) Any person(s) having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer.

(3) Any person holding the shares of voting stock or policyholder proxies of a domestic insurer, for the purpose of controlling the management thereof, as voting trustee or otherwise.

(4) Any person engaged in this state in, or proposing to be engaged in this state in, or holding himself out in this state as so engaging or proposing, or in this state assisting in, the promotion or formation of an insurer or insurance holding corporation, or corporation to finance an insurer or the production of its business.

**41-221. PLACE OF EXAMINATION.**
(1) The examination may be conducted by the director or his accredited examiners at the offices wherever located of the person being examined and at such other places as may be required for determination of matters under examination.
(2) In the case of alien insurers the examination may be so conducted in the insurer's United States offices and at places within the United States, except as otherwise required by the director.

**41-232. HEARINGS IN GENERAL**.
(1) The director may hold a hearing which he deems necessary for any purpose within the scope of this code.
(2) The director shall hold a hearing:
(a) If required by any provision of this code; or
(b) Upon written demand for a hearing by a person aggrieved by any act, threatened act or failure of the director to act, or by any report, rule, regulation or order of the director (other than an order for the holding of a hearing, or an order on a hearing of which hearing such person had actual notice or pursuant to such order).
(3) Any such demand for a hearing shall summarize the information and grounds to be relied upon as a basis for the relief to be sought at the hearing.
(4) The director shall hold such demanded hearing within thirty (30) days after his receipt of the demand, unless postponed by mutual consent. Failure to hold the hearing shall constitute a denial of the relief sought, and shall be the equivalent of an order on hearing for the purpose of an appeal.
(5) In any administrative proceeding of the director where a hearing is otherwise authorized or required by law, if a party with respect to whom the hearing is to be held waives the hearing in writing, or fails to plead, or to defend or prosecute, as the case may be, and that fact is made known to the director by affidavit or otherwise, the right of hearing shall be deemed to have been waived, and, any other provision of this code to the contrary notwithstanding, without holding or concluding a hearing the director may, upon satisfactory proof of service of the petition or complaint upon such a party, enter an order which shall be as lawful as to such party as if all allegations in the petition or complaint relative to or concerning such party were proved or admitted at a hearing. For good cause shown, the director may, in his discretion, set aside any order so entered, and the proceedings may continue as if no waiver or default had existed.

**41-235. NOTICE OF HEARING.**
(1) Except where a longer period of notice is provided by other provisions of this code relative to particular matters, not less than fourteen (14) days in advance the director shall give notice of the time and place of the hearing, stating the matters to be considered thereat. If the persons to be given notice are not specified in the provision pursuant to which hearing is held, the director shall give such notice to all persons whose pecuniary interests are to be directly and immediately affected by such hearing.
(2) If any such hearing would otherwise require separate notices to more than one hundred (100) persons, in lieu of the notice required under such subsection the director may give notice of the hearing by publishing the notice in at least three (3), but not to exceed five (5), daily newspapers, at least once each week during the four (4) weeks immediately preceding the week in which the hearing is to be held. The director shall select such newspapers, as to location and circulation, as he deems necessary to give adequate opportunity of notice to such persons as should receive notice of the hearing. The published notice shall state the time and place of the hearing and shall specify the matters to be considered thereat. At the time of first publication the director shall mail to every advisory organization which has filed with him pursuant to section 41-1425, Idaho Code, a copy of the published notice if the proposed hearing would affect any interest of the members of such advisory organization.
(3) All such notices, other than published notices, shall be given as provided in section 41-212, Idaho Code.

**41-240. ORDER ON HEARING.**
(1) In the conduct of hearings under this code and making his order thereon, the director shall act in a quasi-judicial capacity.
(2) Within thirty (30) days after termination of a hearing and completion of the transcript, if any, or of any rehearing thereof or reargument thereon, or within such other period as may be specified in this code as to particular proceedings, the director shall make his order on hearing and, subject to subsection (5) below, shall give a copy of the order to each person to whom notice of the hearing was given or required to be given and to any other person who became a party to the hearing by intervention.
(3) The order shall contain a concise statement of the facts as found by the director, and of his conclusions therefrom, and the matters required by section 41-212 (orders, notices).
(4) The order may confirm, modify, or nullify action taken under an existing order, or may constitute the taking of any new action coming within the scope of the notice of the hearing.
(5) If notice of the hearing was given by publication as provided for in section 41-235 the director may publish the order on hearing once each week for four (4) consecutive weeks in the same newspapers in which such notice was published, the first such publication to be made on the date of the order. Publication of the order shall be in lieu of the giving of copies of the order as required under subsection (2) above. At time of first publication the director shall mail to every advisory organization which has filed with him pursuant to section 41-1425, a copy of the published order if the order would affect any interest of members of such advisory organization.

**41-247. INQUIRY POWERS OF DIRECTOR.**
The director shall have power to direct an inquiry in writing to any person subject to his jurisdiction with respect to any insurance transaction or matter relative to a subject of insurance resident, located, or to be performed in this state. The person to whom such an inquiry is addressed shall upon receipt thereof promptly furnish to the director all requested information which is in his possession or subject to his control.

**41-258. REPORT OF LOSSES BY FIRE INSURANCE COMPANIES TO STATE FIRE MARSHAL.**
Every fire insurance company authorized to transact business in this state is hereby required to report to the office of the state fire marshal, within seven (7) days after settlement of all fire losses of one thousand dollars ($1,000) or more, on property within the state of Idaho and all fire losses resulting in death or personal injury, including those personal injury losses covered by workmen's compensation insurance. The report shall state the date of fire, the amount of probable property loss or personal injury, the character of property destroyed or damaged, and supposed cause of the fire. The report shall be in addition to and not in lieu of any report or reports such companies may be required by any law of this state to make to any other state officer.

**41-290. FRAUDULENT CLAIMS.**
Any insurer which has facts to support a belief that a fraudulent claim is being or has been made shall, within sixty (60) days of the receipt of such notice, send to the director of insurance, on a form prescribed by the director, the information requested and such additional information relative to the claim and the parties claiming loss or damages as the director may require. The director of the department of insurance shall review such reports and select such claims as, in his judgment, may require further investigation. He shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim. The director of the department of insurance shall report any alleged violations of law which his investigations disclose to the appropriate licensing agency and prosecuting authority having jurisdiction with respect to any such violation.
If, upon examination, the director of the department of insurance determines that an insurer has intentionally not reported a claim when the insurer had facts to support a belief that the claim was fraudulent in accordance with the provisions of this chapter, the director may impose fines and penalties pursuant to section 41-327, Idaho Code, for each unreported suspected fraudulent claim.

**41-293. INSURANCE FRAUD.**
Insurance fraud includes:
(1) (a) Any person who, with the intent to defraud or deceive an insurer for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, producer, practitioner or other person, any statement as part of, or in support of, a claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim; or
(b) Any person who, with intent to defraud or deceive an insurer assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to any insurer, producer, practitioner or other person, in connection with, or in support of, any claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim;
(c) Any person who, with intent to defraud or deceive, presents or causes to be presented to or by an insurer, a producer, practitioner or other person, a false or altered statement material to an insurance transaction;
(d) Any insurance producer or other person who, with intent to defraud or deceive, willfully takes premium money knowing that insurance coverage will not be effected;
(e) Any practitioner or other person who willfully submits a false or altered statement, with the intent of deceiving an insurer or other person in connection with an insurance transaction or claim;
(f) Anyone willfully making a false statement or material misrepresentation to an insurer, employer, practitioner or other person, with the intent to defraud or deceive an insurer or other person, to obtain or extend worker's compensation benefits;
(g) Anyone who offers or accepts a direct or indirect inducement to file or solicits another person to file a false statement, with intent to defraud or deceive an insurer;
(h) Any person who, with intent to defraud or deceive, transacts insurance of any kind or character, or transmits for a person other than himself an application for a policy of insurance, without proper licensing or after such license has been suspended or revoked;
(i) Any practitioner or any other person who, with intent to defraud or deceive, employs, uses or acts as a runner for the purpose of submitting a claim containing false, incomplete, or misleading information concerning any fact or thing material to such claim;
(j) Any employer or other person who, with intent to defraud or deceive, presents or causes to be presented to an insurer, producer or any other person or governmental agency any statement containing the number of employees, amount of payroll, job description or job title or any other statement material to worker's compensation insurance which contains false, misleading or incomplete information; or
(k) Any person who, with intent to defraud or deceive, obstructs the director in the conduct of any authorized examination.
(2) A fact, statement or representation is "material" if it includes any of the following:
(a) Any fact which, if communicated to the producer, insurer, adjuster or representative thereof, would induce him to either decline insurance altogether or not accept it unless a higher premium is paid by the insured;
(b) Any fact relating to a claim for insurance benefits which, if disclosed, would be a fair reason for rejecting a claim for insurance benefits;
(c) Any fact, the knowledge or ignorance of which would naturally influence the insurer in making or refusing the contract, in estimating the degree or character of the risk, or in fixing the rate of premium;
(d) Any fact, the knowledge or ignorance of which would naturally influence the insurer in accepting or rejecting a claim for insurance benefits or compensation, or in determining the amount of compensation or insurance benefits to be paid to the insured; or
(e) Any fact that necessarily has some bearing on the subject matter of the insurance coverage or claim for benefits under an insurance contract.
(3) Any offense committed by use of a telephone, any means of electronic communication or mail as provided by this chapter may be deemed to have been committed at the place from which the telephone call or electronic communication was made, or mail was sent, or the offense may be deemed to have been committed at the place at which the telephone call, electronic communication or mail was received.
(4) Any violator of this section is guilty of a felony and shall be subject to a term of imprisonment not to exceed fifteen (15) years, or a fine not to exceed fifteen thousand dollars ($15,000), or both and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section. Each instance of violation may be considered a separate offense.

**41-301. "STOCK" INSURER DEFINED**.
For the purposes of this code a "stock" insurer is an incorporated insurer with its capital divided into shares and owned by its stockholders.

**41-302. "MUTUAL" INSURER DEFINED**.
A "mutual" insurer is an incorporated insurer without capital stock and the governing body of which is elected by its policy holders. This definition shall not be deemed to exclude as "mutual" insurers certain foreign insurers found by the director to be organized on the mutual plan under the laws of their states of domicile, but having temporary share capital or providing for election of the insurer's governing body on a reasonable basis by policy holders and others.

**41-305. CERTIFICATE OF AUTHORITY REQUIRED**.
(1) No person shall act as an insurer and no insurer or its agents, attorneys, subscribers, or representatives shall directly or indirectly transact insurance in this state except as authorized by a subsisting certificate of authority issued to the insurer by the director, except as to such transactions as are expressly otherwise provided for in this code.
(2) No insurer shall from offices or by personnel or facilities located in this state solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority issued to it by the director authorizing it to transact the same kind or kinds of insurance in this state.

**41-306. EXCEPTIONS TO CERTIFICATE OF AUTHORITY REQUIREMENT**.
A certificate of authority and application therefor pursuant to section 41-319, Idaho Code, shall not be required of an insurer with respect to the following:
(1) Investigation, settlement, or litigation of claims under its policies lawfully written in this state, or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in this state.
(2) Transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this state at time of issuance, and lawfully solicited, written and delivered outside this state.
(3) Transactions pursuant to surplus lines coverages lawfully written under chapter 12, title 41, Idaho Code.
(4) Reinsurance, when transacted by an insurer duly authorized by its state of domicile to transact the kind of insurance involved.
(5) The continuation and servicing of life insurance or disability insurance policies or annuity contracts remaining in force as to residents of this state if the insurer has withdrawn from the state and is not transacting new insurance therein.
(6) A foreign insurer licensed and authorized to sell individual or group accident and sickness insurance in another state as defined pursuant to section 41-306A, Idaho Code, and the insurer obtains a certificate of authority pursuant to that section.

**41-501. DEFINITIONS NOT MUTUALLY EXCLUSIVE.**
It is intended that certain insurance coverages may come within the definitions of two (2) or more kinds of insurance as defined in this chapter, and the inclusion of such coverage within one (1) definition shall not exclude it as to any other kind of insurance within the definition of which such coverage is likewise reasonably includable.

**41-502. "LIFE INSURANCE" DEFINED.**
"Life insurance" is insurance on human lives. The transaction of life insurance includes also the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, and optional modes of settlement of proceeds of life insurance. Life insurance does not include workmen's compensation coverages.

**41-1003. DEFINITIONS**.
(1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.
(2) "Home state" means the District of Columbia and any state or territory of the United States or any province of Canada in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.
(3) "License" means a document issued by the director authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.
(4) "Limited lines insurance" is insurance which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 41-1008(1)(a) through (g), Idaho Code, and shall include, but not be limited to: credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance, transportation baggage insurance, transportation ticket policies covering personal accident insurance, pet insurance, portable electronics insurance, travel insurance or any other line of insurance that the director deems necessary to recognize for the purposes of complying with section 41-1009(5), Idaho Code.
(5) "Limited lines producer" means a producer authorized by the director to sell, solicit or negotiate limited lines insurance. "Limited lines producer" includes a "limited lines travel insurance producer" as used in sections 41-1090 through 41-1096, Idaho Code.
(6) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in the act either sells insurance or obtains insurance from insurers for purchasers.
(7) "Person" means an individual or a business entity.
(8) "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.
(9) "Resident" means a person whose home state is Idaho or any other particular state identified in conjunction with the use of the term.
(10) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.
(11) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company or companies.
(12) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance for or on behalf of an insurer.
(13) "Uniform application" means the current version of the national association of insurance commissioners (NAIC) uniform application for resident and nonresident producer licensing.
(14) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

**41-1004. LICENSE REQUIRED**.
(1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed as a producer for that line of authority in accordance with this chapter.
(2) A person shall not, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho unless that person is:
(a) A licensed insurance producer offering advice concerning a class of insurance as to which the producer is licensed to transact business in this state;
(b) An attorney rendering services in the performance of the duties of an attorney;
(c) A certified public accountant rendering services in the performance of the duties of a certified public accountant, as authorized by law;
(d) An actuary rendering actuarial services if such actuary is a member of an organization determined by the director as establishing standards for the actuarial profession;
(e) A person providing services to producers or authorized insurers only;
(f) A person rendering services as an expert pursuant to the Idaho rules of evidence;
(g) An investment adviser, investment adviser representative or federally covered investment adviser as defined in section 30-14-102, Idaho Code; or
(h) A person rendering such services pursuant to a license issued in accordance with sections 41-1081 through 41-1089 of this chapter [, Idaho Code].

**41-1005. EXCEPTIONS TO LICENSING**.
(1) Nothing in this chapter shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.
(2) A license as an insurance producer shall not be required of the following:
(a) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:
(i) The activities of the officer, director or employee are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or
(ii) The function of the officer, director or employee relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or
(iii) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;
(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans, or performs administrative services relating to mass-marketed property and casualty insurance, and who does not receive a commission;

(c) An employer or association or its officers, directors, employees or the trustees of an employee trust plan, to the extent that the employer, association, officer, employee, director or trustee is engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which involves the use of insurance issued by an insurer, as long as the employer, association, officer, director, employee or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contracts;
(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation or negotiation of insurance, and who do not receive a commission;
(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;
(f) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one (1) state insured under that contract, provided that the person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;
(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; or
(h) A person who, concurrent with the rental of a motor vehicle, provides contract options to the standard rental agreement which provides auto and travel related coverages through authorized insurers during a rental period not to exceed ninety (90) days.

**41-1006. APPLICATION FOR EXAMINATION.**

(1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to section 41-1008(4) or 41-1012, Idaho Code. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the director of the department of insurance.
(2) Each individual applying for an examination shall remit a nonrefundable fee as promulgated by the director pursuant to section 41-401, Idaho Code.
(3) An individual who fails to appear for the examination as scheduled or who fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.
(4) Applications for licensure not received by the department within one hundred eighty (180) days of the successful completion of the examination shall be denied.

**41-1007. APPLICATION FOR PRODUCER LICENSE.**

(1) A person applying for a resident insurance producer license shall make application to the director on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief. Before approving the application, the director shall find that the applicant:
  (a) Is at least eighteen (18) years of age;
  (b) Has submitted the applicant's fingerprints as may be required by the director;
  (c) Has not committed any act that is a ground for denial, suspension or revocation of the license as set forth in title 41, Idaho Code;
  (d) Has paid the fees prescribed by the director pursuant to section 41-401, Idaho Code; and
  (e) Has successfully passed the examinations for the lines of authority for which the applicant has applied.
(2) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the director shall find that:
  (a) The business entity has paid the fees prescribed by the director pursuant to section 41-401, Idaho Code; and
  (b) The business entity has designated a licensed producer, who is an individual responsible for the business entity's compliance with the insurance laws and rules of this state.
(3) The director may require any documents which are reasonably necessary to verify the information contained in an application.
(4) Each insurer that sells, solicits or negotiates any form of limited line insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited lines insurance a program of instruction that may be required to be approved by the director. If acceptable to the director, and as stated by rule, the program of instruction may be administered in place of the examination as required in section 41-1006, Idaho Code. In addition, such course of instruction may be administered in place of any continuing education requirements pursuant to section 41-1013, Idaho Code.

**41-1008. PRODUCER LICENSE.**

(1) Unless denied licensure pursuant to section 41-1016, Idaho Code, persons who have met the requirements of sections 41-1006 and 41-1007, Idaho Code, shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:
  (a) Life insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;
  (b) Disability, including accident and health or sickness insurance coverage for sickness, bodily injury or accidental death and benefits for disability income;
  (c) Property insurance coverage for the direct or consequential loss or damage to property of every kind;
  (d) Casualty insurance coverage against legal liability, including liability for death, injury or disability or damage to real or personal property;
  (e) Variable life and variable annuity products, meaning insurance coverage provided under variable life insurance contracts and variable annuities;
  (f) Personal lines, meaning property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;
  (g) Any other line of insurance permitted under state laws or rules.

**41-1009. NONRESIDENT PRODUCER LICENSE.**

(1) Unless denied licensure pursuant to section 41-1016, Idaho Code, a nonresident applicant shall receive a nonresident producer license if:
   (a) The applicant is currently licensed as a resident and in good standing in his or her home state;
   (b) The applicant has submitted the proper request for licensure and has paid the fees set forth by rule pursuant to section 41-401, Idaho Code;
   (c) The applicant has submitted or transmitted to the director the application for licensure that the applicant submitted to his or her home state or, in lieu of such application, a completed uniform application;
   (d) The applicant has submitted the applicant's fingerprints, if required by the director, on a form as prescribed by the director; and
   (e) The applicant's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The director may verify the producer's licensing status through the producer database maintained by the national association of insurance commissioners, its affiliates or subsidiaries, or by any other acceptable means.

(3) A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application shall be required for filing the change of address.

(4) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines broker in his or her home state shall receive a nonresident surplus lines broker license pursuant to subsection (1) of this section. Except as to subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of section 41-1223, Idaho Code.

(5) Notwithstanding any other provision of this chapter, a person licensed as a limited lines producer in his or her home state shall receive a nonresident limited lines producer license, pursuant to subsection (1) of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 41-1008(1)(a) through (g), Idaho Code.

**41-1010. NONRESIDENT PRODUCERS — SERVICE OF PROCESS.**

(1) Each person applying to be a nonresident producer shall, on a form prescribed by the director, appoint the director as his agent for purposes of receiving service of legal process issued against the producer in this state upon causes of action arising within this state out of transactions under the license. Service upon the director as an agent shall constitute effective legal service upon the producer.

(2) The appointment shall be irrevocable for as long as there could be any cause of action against the licensee arising out of his insurance transactions in or with respect to this state.

(3) Duplicate copies of such legal process against the licensee shall be served upon the director by a person competent to serve a summons. At the time of service the plaintiff shall pay the director an appropriate fee to be determined by rule and not exceeding thirty dollars ($30.00).

(4) Upon receiving such service, the director shall send one (1) copy of the process by registered or certified mail with return receipt requested to the defendant licensee at his last address of record with the director.

(5) The director shall keep a record of the day and hour of such service upon him. No proceedings shall be brought against the producer, and the producer shall not be required to appear, plead or answer until the expiration of thirty (30) days after the date of service upon the director.

**41-1011. ISSUANCE — REFUSAL OF LICENSE.**

If after completion of application for a license, the taking and passing of any examination required under this chapter and, if required by the director, receipt of a report from the federal bureau of investigation based on the fingerprints of the applicant, the director finds that the applicant has fully met the requirements for a license, the director shall issue the license to the applicant; otherwise, the director shall refuse to issue the license and shall promptly notify the applicant and any appointing insurer or insurers of such refusal and state the grounds for the refusal. Pending the receipt of the report from the federal bureau of investigation, the director may, in his discretion, issue a temporary license if all other qualifications have been met.

**41-1012. EXEMPTION FROM EXAMINATION**.

(1) An individual who applies for an insurance producer license in this state and who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing examination if:
   (a) The person is currently licensed in another state; or
   (b) The application is received within ninety (90) days of the cancellation of the applicant's previous license and the prior state issues a certification that:
      (i) At the time of cancellation, the applicant was in good standing in that state; or
      (ii) The state's producer database records, as maintained by the national association of insurance commissioners or its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the lines of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to section 41-1006, Idaho Code. No examination shall be required of that person to obtain any line of authority previously held in the prior state unless the director provides otherwise by rule.

**41-1013. CONTINUATION — EXPIRATION OF LICENSES — CONTINUING EDUCATION STATEMENT**.

(1) All producer, adjuster, and surplus line broker licenses issued under this code shall continue in force until expired, suspended, revoked or otherwise terminated, subject to payment of the applicable continuation fee on or before the expiration date referred to in subsection (2) of this section, accompanied by a written request for such continuation and a continuing education statement verifying that the licensee has completed any continuing education requirements imposed by the director. An application for renewal is not complete unless it is submitted with both the applicable fee and the completed continuing education statement. Requests for continuation shall be made in writing on forms to be prescribed by the director.

(2) The director may fix the dates of expiration for licenses in such manner as is deemed by him to be advisable for an efficient distribution of the workload of his office. If the expiration date for a particular license or appointment would shorten the period for which the license or appointment continuation fee has been paid, no refund of an unearned fee shall be made. If the expiration date for a particular license or appointment would lengthen the period for which a license or appointment continuation fee has been paid, the director shall charge no additional fee for such lengthened period.

(3) Any license referred to in subsection (1) of this section for which no request for continuation, fee and completed continuing education statement are timely received by the director shall be deemed to have expired at midnight on the applicable expiration date.

(4) All sums tendered as fees for continuations of licenses as producer, limited lines producer, adjuster or surplus line broker shall be deemed earned when paid and shall not be subject to refund, except that the director shall refund any duplicate payment of fees.

*41-1013. CONTINUATION — EXPIRATION OF LICENSES — CONTINUING EDUCATION STATEMENT (continued).*

(4) All sums tendered as fees for continuations of licenses as producer, limited lines producer, adjuster or surplus line broker shall be deemed earned when paid and shall not be subject to refund, except that the director shall refund any duplicate payment of fees.
(5) For the protection of the people of this state the director shall establish, by rule, additional educational requirements designed to maintain and improve the insurance skills and knowledge of resident producers after licensure by the department of insurance. The director shall also establish, by rule, an advisory committee comprised of representatives from each segment of the insurance industry to assist the director in prescribing additional educational requirements. Such rules promulgated by the director shall include limits on the terms of service for members of the committee.
(6) Subject to subsection (3) of this section, the director shall not permit to be continued the license of any producer who is licensed pursuant to section 41-1007, Idaho Code, who is a resident of this state, unless such person has demonstrated to the satisfaction of the director that in addition to meeting the standards contained in sections 41-1007, (qualifications for producer license), Idaho Code, as may be applicable, all the additional educational requirements as the director may prescribe by rule have been met.
(7) Failure of the licensee to comply with any applicable additional education requirements prescribed by the director by rule by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars (sections 41-1007, (qualifications for producer license), Idaho Code, as may be applicable, all the additional educational requirements as the director may prescribe by rule have been met.
(7) Failure of the licensee to comply with any applicable additional education requirements prescribed by the director by rule by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars ($100) for a delinquency of one (1) day to thirty (30) days, two hundred dollars ($200) for a delinquency of00) for a delinquency of one (1) day to thirty (30) days, two hundred dollars (00) for a delinquency of thirty-one (31) days to sixty (60) days, and three hundred dollars ($300) for a delinquency of sixty-one (61) days to ninety (90) days. Following the ninetieth day from the date of nonrenewal of the license and up to one (1) year from the nonrenewal date, the licensee must complete all requirements for licensure including retesting, submission of a new application and payment of all new licensing fees. In addition, the individual must submit proof of completion of the required education requirements for the licensing period in which the license was terminated. After the license has been expired for one (1) year or more, the individual must reapply and retest as a new applicant.

**41-1016. ADMINISTRATIVE PENALTY — SUSPENSION, REVOCATION, REFUSAL OF LICENSE.**

(1) The director may impose an administrative penalty not to exceed one thousand dollars ($1,000), for deposit in the general fund of the state of Idaho, and may suspend for not more than twelve (12) months or may revoke or refuse to issue or continue any license issued under this chapter, chapter 27, title 41, Idaho Code (title insurance), chapter 11, title 41, Idaho Code (adjusters), or chapter 12, title 41, Idaho Code (surplus lines brokers), if the director finds that as to the licensee or applicant any one (1) or more of the following causes or violations exist:
   (a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;
   (b) Violating any provision of title 41, Idaho Code, department rule, subpoena or order of the director or of another state's insurance director;
   (c) Obtaining or attempting to obtain a license through misrepresentation or fraud;
   (d) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;
   (e) Misrepresenting the terms of an actual or proposed insurance contract or application for insurance or misrepresenting any fact material to any insurance transaction or proposed transaction;
   (f) Being convicted of or pleading guilty to a crime that is deemed relevant in accordance with section 67-9411(1), Idaho Code, or that evidences dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public;
   (g) Admitting or being found to have committed any insurance unfair trade practice or fraud;
   (h) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, or being a source of injury and loss to the public or others, in the conduct of business in this state or elsewhere;
   (i) Having an insurance license denied, suspended or revoked in any other state, province, district or territory;
   (j) Forging another's name on an application for insurance or on any document related to an insurance transaction;
   (k) Improperly using notes or any other reference material to complete an examination for an insurance license;
   (l) Knowingly accepting insurance business from an individual who is not licensed;
   (m) Failing to comply with an administrative or court order imposing a child support obligation, provided however, that nothing in this provision shall be deemed to abrogate or modify chapter 14, title 7, Idaho Code;
   (n) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax; or
   (o) In the case of a bail agent, compensating or agreeing to compensate any incarcerated person to influence or encourage another incarcerated person or other incarcerated persons to engage the bail agent's services or the services of the bail agent's company or of other bail agents employed by such bail company. For purposes of this subsection, compensating any incarcerated person shall include providing payment in any form to any person, organization or entity designated by the incarcerated person to receive such payment.
(2) The director shall, without hearing, suspend for not more than twelve (12) months, or shall revoke or refuse to continue any license issued under this chapter to a nonresident where:
   (a) The director has received a final order of suspension, revocation or refusal to continue from the insurance regulatory official or court of jurisdiction of the licensee's home state; or
   (b) A nonresident no longer has a license in the licensee's home state because the home state license was:
      (i) Voluntarily surrendered for any reason except relicensing as a resident in another state; or
      (ii) Otherwise nonrenewed by the nonresident and remains nonrenewed for a period greater than ninety (90) days beyond its expiration date, and without notice to the director of relicensing as a resident in another state. If cause under this provision exists after the expiration of the twelve (12) months, successive suspensions may be imposed by the director without hearing.
(3) The license of a business entity may be suspended, revoked or refused if the director finds that the violation of an individual licensee, who is registered to or acting on behalf of the business entity, was known or should have been known by one (1) or more of the owners, officers or managers acting on behalf of the business entity and that the violation was not reported to the director and no corrective action was taken.
(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine or administrative penalty pursuant to subsection (1) of this section or any other applicable section.
(5) The director shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by title 41, Idaho Code, against any person who is under investigation for or charged with a violation of title 41, Idaho Code, or department rule, even if the person's license or registration has been surrendered or has lapsed by operation of law, or if the person has never been licensed.

**41-1017. COMMISSIONS**.

(1) An insurance company or insurance producer shall not pay a commission, service fee or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(2) A person shall not accept a commission, service fee or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(3) Renewals or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if that person was duly licensed as required under this chapter at the time of the sale, solicitation or negotiation.

(4) An insurer or insurance producer may pay or assign commissions, service fees or other valuable consideration to any person, regardless of whether that person is licensed as a producer, unless the payment or assignment would violate a specific section of title 41, Idaho Code, including, but not limited to, sections 41-1314 and 41-2708, Idaho Code, or department rule.

**41-1018. APPOINTMENTS.**

(1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the director, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted.

(3) Upon receipt of the notice of appointment, the director shall verify, within a reasonable time not to exceed thirty (30) days, that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the director shall notify the insurer within five (5) days of his determination.

**41-1019. NOTIFICATION TO DIRECTOR OF TERMINATION.**

(1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director, if the reason for termination is one of the reasons set forth in section 41-1016, Idaho Code, or the insurer has knowledge that the producer was found by a court, governmental body or self-regulatory organization authorized by law to have engaged in any of the activities set forth in section 41-1016, Idaho Code. Upon the written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer for any reason not set forth in section 41-1016, Idaho Code, shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director. Upon written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

(3) The insurer or authorized representative of the insurer shall promptly notify the director in a format acceptable to the director if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the director in accordance with subsection (1) of this section.

(4) A copy of any notification shall be provided to the producer as follows:

(a) Within fifteen (15) days after making the notification required by subsections (1), (2) and (3) of this section, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any other reasons listed in section 41-1016, Idaho Code, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(b) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the director. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the director's file and shall accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (6) of this section.

(5) Immunities.

(a) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the director, or an organization of which the director is a member and that compiles information and makes it available to other insurance directors or regulatory or law enforcement agencies, shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the director from an insurer or producer or as a result of any statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (1) of this section was reported to the director, provided that the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) In any action brought against a person that may have immunity under paragraph (a) of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the director, the party bringing the action shall plead specifically in any allegation that paragraph (a) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(c) Paragraph (a) or (b) of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

(6) Confidentiality.

(a) Any documents, materials or other information obtained by the director in an investigation pursuant to this section shall be exempt from public disclosure under chapter 1, title 74, Idaho Code.

(b) In order to assist in the performance of the director's duties under this chapter, the director:

(i)May share documents, materials or other information, including confidential and privileged documents and materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies and law enforcement authorities, and with the national association of insurance commissioners, its affiliates or subsidiaries, provided that the recipient agrees to maintain the confidentiality and privileged status of the documents, materials or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or subsidiaries and from regulatory agencies and law enforcement authorities of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials or information received with notice or with the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(c) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in paragraph (b) of this subsection.

(d) Nothing in this chapter shall prohibit the director from releasing final adjudicated actions, including for cause terminations that are open to public inspection pursuant to chapter 1, title 74 and title 41, Idaho Code, to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

*41-1019. NOTIFICATION TO DIRECTOR OF TERMINATION (continued)* .

(7) Penalties for failing to report. An insurer, the authorized representative of the insurer, or a producer who fails to report as required under the provisions of this section or who is found by a court of competent jurisdiction to have reported with actual malice may, after notice and hearing, have his license or certificate of authority suspended or revoked and may be fined in accordance with section 41-1016 or 41-327, Idaho Code.

**41-1021. REPORTING OF ACTIONS.**

(1) A producer shall report to the director any administrative action taken against the producer in another jurisdiction or by another governmental agency within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent order or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the director any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

**41-1024. REPORTING AND ACCOUNTING FOR PREMIUMS**.

(1) All fiduciary funds received or collected by a producer shall be trust funds received by the producer in a fiduciary capacity, and the producer shall, in the applicable regular course of business, account for and pay the same to the person entitled to the funds. The producer shall establish a separate account for funds belonging to others in order to avoid a commingling of such fiduciary funds with his own funds. The producer may deposit and commingle in such separate account all fiduciary funds so long as the amount of such deposit so held for all other persons is reasonably ascertainable from the records and accounts of the producer. A producer who duly collects and deposits funds into a sweep account maintained by or for the benefit of an applicable insurer shall not be deemed to be in violation of the fiduciary fund account requirement. The director may promulgate rules relating to accounting for and handling of fiduciary funds and the fiduciary fund account.

(2) Fiduciary funds shall include all funds collected by an insurance producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or the producer's employer, and all funds collected by an insurance producer from an insurance company or its agents that are to be paid to a policyholder or claimant under any contract of insurance.

(3) Any producer who, not being lawfully entitled thereto, diverts or appropriates to his own use such trust or fiduciary funds or any portion thereof, whether or not such funds have been separately deposited, shall upon conviction be guilty of a felony.

**41-1026. PROCEDURE FOLLOWING SUSPENSION, REVOCATION, DENIAL — REINSTATEMENT**.

(1) Upon suspension, revocation, or refusal to continue any license, the director shall notify the licensee as provided in section 41-212(3), Idaho Code, and, in the case of a producer who holds appointments from insurers, shall give like notice to the insurers represented.

(2) Suspension, revocation, or refusal of any one (1) license held by the licensee under title 41, Idaho Code, shall automatically suspend, revoke or refuse continuation of all other licenses held by the licensee under title 41, Idaho Code.

(3) The director shall not issue a license under title 41, Idaho Code, to or as to any person whose license has been revoked or continuance refused until after the expiration of not less than one (1) year, to a maximum of five (5) years, from the date of such revocation or refusal, which time period shall be set forth in the final order, or, if judicial review of such revocation or refusal is sought, not less than one (1) year, to a maximum of five (5) years, from the date of a final court order or decree affirming the revocation or refusal. If no time period is specified in the final order or final court order or decree, the time period shall be one (1) year. In the event the former licensee again files an application for a license under title 41, Idaho Code, the director may require the applicant to show good cause why the prior revocation or refusal to continue his license shall not be deemed a bar to the issuance of a new license.

(4) The director shall not issue a license under title 41, Idaho Code, to any person whose application for a license was previously denied until after the expiration of one (1) year from the date of such license denial or, if judicial review of such license denial is sought, one (1) year from the date of a final court order or decree affirming the license denial.

**41-1030. PRODUCER COMPENSATION.**

(1) For purposes of this section:
- (a) "Consumer" means an insured, a prospective insured or an employer group.
- (b) "Retail producer" means a producer who solicits, negotiates with or sells an insurance contract directly to a consumer.
- (c) "Wholesale producer" means a producer who solicits, negotiates or sells an insurance contract directly with a retail producer, but not with a consumer.

(2) Notwithstanding any other provision of title 41, Idaho Code, and as provided in this subsection, retail producers and wholesale producers may charge a fee or be compensated by a combination of fees and commissions.
- (a) Before charging a fee to a consumer, a retail producer shall provide to the consumer a written statement that describes the services the retail producer will perform and the fees the retail producer will receive. Acceptance by the consumer of a fee arrangement shall be evidenced by the consumer signing and dating the fee statement.
- (b) Before charging a fee to a retail producer, a wholesale producer shall provide to the retail producer a written statement that describes the services the wholesale producer will perform and the fees the wholesale producer will receive. Information regarding the amount of the fees charged by the wholesale producer shall be disclosed in writing on the face of the policy as a separately itemized charge.

**41-1036. RECORDS**.

(1) A producer holding a license under this chapter shall make available through his principal place of business complete records of transactions placed through or countersigned by the producer.

(2) Records as provided in subsection (1) of this section shall include, but not be limited to:
- (a) The names and addresses of insurer and insured;
- (b) The number and expiration date of the policy or contract;
- (c) The premium payable as to the policy or contract;
- (d) The date, time, insurer, insured and coverage of every binder made by the producer;
- (e) All disclosures made by a producer to an insured or to a prospective insured; and
- (f) Such other information as the director may reasonably require.

(3) The records shall be kept available for inspection by the director for at least five (5) years after the creation or the completion, whichever is later, of the respective transactions. The records may be maintained off-site and in electronic form if the records can be made available for inspection through the producer's principal place of business upon reasonable notice by the director.

**41-1103. LICENSE REQUIRED.**
No person shall in this state be, act as, or advertise or hold himself out to be, an adjuster unless then licensed as an adjuster under this chapter. No resident of Canada may be licensed as a resident adjuster or may designate Idaho as his home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable provisions of this chapter. No resident of Canada may be licensed as a nonresident adjuster unless such person has obtained a resident or home state adjuster license in another state.

**41-1104. QUALIFICATIONS FOR ADJUSTER'S LICENSE**.
(1) Except as provided in subsection (2) of this section, the director shall not issue, continue, or permit to exist any license as an adjuster as to any person not qualified therefor as follows:
   (a) Must be a natural person not less than twenty-one (21) years of age.
   (b) Must be trustworthy, and be of good character and reputation as to morals, integrity, and financial responsibility, and must not have been convicted of any crime that is deemed relevant in accordance with section 67-9411(1), Idaho Code.
   (c) Must be a salaried employee of a licensed adjuster, or must have had experience or special education or training as to the investigation and settlement of loss of claims under insurance contracts of sufficient duration and extent reasonably to satisfy the director as to his competence to fulfill the responsibilities of an adjuster.
   (d) If required by the director, must pass a written examination to test his knowledge of the duties and responsibilities of an adjuster and of matters involved in transactions under an adjuster's license. The examination shall be subject to the same applicable provisions as apply pursuant to title 41, Idaho Code, to examinations for license as insurance agent.
(2) A firm or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers in this state is separately licensed, or is named in the firm or corporation license, and is qualified as for an individual license as adjuster under subsection (1) of this section. An additional full license fee shall be paid as to each individual in excess of one (1) so named in the firm or corporation license to exercise its powers.

**41-1223. LICENSING OF SURPLUS LINE BROKERS.**
(1) Any individual while licensed as a producer licensed for property or casualty insurance who has had at least two (2) years' experience as a producer for the lines of insurance for which he is seeking to be licensed as a surplus line broker, and who is deemed by the director to be competent and trustworthy with respect to the handling of surplus lines, may be licensed as a surplus line broker.
(2) Application for the license shall be made to the director on forms as designated and furnished by the director.
(3) The license and continuation fee shall be as set forth by rule pursuant to section 41-401, Idaho Code.
(4) The license and licensee shall be subject to the applicable provisions of chapter 10, title 41, Idaho Code (producer licensing).
(5) When a national insurance producer database of the national association of insurance commissioners, or other equivalent uniform national database, for the licensure of surplus line brokers is created, the director may participate in such database.

**41-1303. MISREPRESENTATION OR FALSE ADVERTISING OF POLICIES.**
(1) No person shall make, issue, circulate, or cause to be made, issued, or circulated, any estimate, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.
(2) No person shall misrepresent a policy for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
(3) No person shall misrepresent any insurance policy as being shares of stock.
(4) For reasonable cause the director may in his discretion require any insurer or agent using or proposing to use in this state a prospectus, offering sheet, or other sales literature or printed sales aids in the solicitation of life or disability insurance to file the same with him for review. The director shall forthwith by order disapprove any such prospectus, sheet, literature, or aid found by him to be in violation of this section. The order shall become effective on the effective date specified therein, which date shall not be less than ten (10) days after the date the order was issued and mailed to the insurer or agent affected thereby; except, that if the insurer or agent prior to such effective date makes written request to the director for a hearing relative to the matter the director's order shall thereby be stayed pending the hearing and the director's further order on hearing. No insurer, agent, or other representative shall use in this state any prospectus, offering sheet, literature or sales aid after the date an order of disapproval thereof has become effective and has been communicated to the insurer. This provision shall not relieve any person of liability for penalties provided for violation of subsection (1) above.

**41-1304. FALSE INFORMATION AND ADVERTISING WITH RESPECT TO INSURANCE BUSINESS**.
No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement, or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

**41-1305. "TWISTING" PROHIBITED**.
No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, lease, retain, exchange, or convert, or otherwise use or dispose of any insurance policy, or any right or option thereunder, or in connection with any such statement and for like purpose fail to disclose all reasonably material facts, or a material fact necessary to make the statements made, in the light of the circumstances under which they are made, not misleading.

**41-1306. FALSE FINANCIAL STATEMENTS**.
(1) No person shall file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.
(2) No person shall make any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

**41-1308. DEFAMATION**.
No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is circulated to injure any person engaged or proposing to engage in the business of insurance.

**41-1309. BOYCOTT, COERCION AND INTIMIDATION**.
No person or persons shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

**41-1310. PERSON FINANCING PURCHASE OF PROPERTY NOT TO FAVOR INSURER OR AGENT**.
No person engaged in the business of financing the purchase of real or personal property and no trustee, director, officer, agent or other employee of any such person shall require, as a condition to financing the purchase of such property or to loaning money upon the security of a mortgage thereon, or, as a condition for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the money is to be loaned or for whom such extension, renewal or other act is to be granted or performed, purchase or place fire, property damage, theft, collision or personal injury insurance which is required to be maintained by him on the mortgaged property, from or through any particular insurance agent or agents, broker or brokers, or insurer or insurers.

**41-1311. SELLER OF PROPERTY NOT TO FAVOR INSURER OR AGENT.**
No seller of real or personal property, and no person engaged in the business of selling real or personal property, and no trustee, director, officer, agent or other employee of any such seller or such other person shall require, as a condition to the selling of such property, or for the performance of any other act in connection therewith, that the person to whom such property is to be sold, purchase or place any fire, property damage, theft, collision or personal injury insurance covering such property, from any particular insurance agent or agents, broker or brokers, or insurer or insurers

**41-1312. RIGHTS WITH RESPECT TO INSURANCE ON PROPERTY SOLD OR PURCHASED.**
Sections 41-1310 or 41-1311 shall not prevent:

(1) The reasonable exercise by any person engaged in any such business of his right to approve or disapprove the insurance or the insurer selected to write the insurance, on reasonable grounds related to the risk selection or underwriting practices of the insurer, the adequacy and terms of the coverage with respect to the interest of such person to be insured thereunder, the quality of service rendered by the insurer or its representative in connection with the insurance, and the financial standards to be met by the insurer; nor of his right to furnish such insurance or to renew any insurance required by the contract of sale or mortgage, trust deed or other loan agreement if the borrower or purchaser has failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement. The lender or vendor shall not refuse to accept insurance provided by an acceptable insurer on the ground that such insurance provides more coverage than is required in the sale or loan agreement, unless the additional coverage consists of life or disability insurance.

(2) The free choice of insurance agent or broker by any borrower or purchaser at any time, and he may revoke any designation of insurance agent or broker at any time irrespective of the provisions of any loan or purchase agreement, mortgage, or trust deed.

(3) The exercise by any person engaged in such business of his right to furnish such insurance or to renew such insurance, and to charge the account of the borrower or purchaser with the costs thereof, if the borrower or purchaser fails to deliver to the lender or vendor such insurance at least thirty (30) days prior to expiration of the existing policy. If an insurance policy procured by the borrower or purchaser is subsequently substituted for that then in force, the lender or vendor may impose a reasonable service charge as determined by the director for the transaction, and payment of such charge by the agent or broker shall not be a violation of any other provision of this code. No service charge shall be imposed for normal insurance changes made during the term of the policy.

(4) The director may adopt a uniform statewide schedule of permissive maximum charges for the substitution of policies authorized in subdivision (3) above.

**41-1313. UNFAIR DISCRIMINATION — LIFE INSURANCE, ANNUITIES, AND DISABILITY INSURANCE.**
(1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(3) No person shall discriminate on the basis of a genetic test or private genetic information, as those terms are defined in section 39-8302, Idaho Code, in the issuance of coverage, or the fixing of rates, terms or conditions, for any policy or contract of disability insurance or any health benefit plan.

**41-1314. REBATES — ILLEGAL INDUCEMENTS**.
(1) Except as otherwise expressly provided by law, no person shall knowingly make, permit to be made, or offer to make any contract of insurance, or of annuity, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity or in connection therewith, any rebate of premiums payable on the contract, or of any producer's commission related thereto, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or directly or indirectly give, or sell, or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith, and whether or not specified or to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds, or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other person, or any dividends or profits accrued or to accrue thereon; or offer, promise or give anything of value whatsoever not specified in the contract. Nor shall any insured, annuitant, or policyholder or employee thereof, or prospective insured, annuitant or policyholder, or employee thereof, knowingly accept or receive, directly or indirectly, any such prohibited contract, agreement, rebate, advantage, employment, or other inducement.

(2) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed producers, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, the usual and ordinary dividends, savings, or unabsorbed premium deposits.

(3) Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes, goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars ($200) in a calendar year.

(4) Extension of credit for the payment of premium beyond the customary premium payment period without charging and collecting interest at a reasonable rate per annum on the amount of credit so extended and for the duration of such credit is prohibited under this section.

**41-1315. EXCEPTIONS TO DISCRIMINATION OR REBATE PROVISION — LIFE OR DISABILITY POLICIES, AND ANNUITY CONTRACTS**.

Nothing in sections 41-1313 and 41-1314[, Idaho Code,] shall be construed as including within the definition of discrimination or rebates or illegal inducements any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policy holders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policy holders.

(2) In the case of life insurance policies issued on the debit plan, making allowance to policy holders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(4) Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check or payroll deduction plan or other similar plan at a reduced rate reasonably related to the savings made by use of such plan.

(5) Issuance of life or disability insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, or modification of premium or rate based on amount of insurance; but any such issuance or modification shall not result in reduction in premium or rate in excess of savings in administration and issuance expenses reasonably attributable to such policies or contracts.

**41-1321. PROCEDURES AS TO UNDEFINED PRACTICES.**

(1) Whenever the director has reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not expressly prohibited or defined in this chapter, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon as provided for in chapter 2, title 41, Idaho Code, or seek any other relief authorized by title 41, Idaho Code.

**41-1323. ILLEGAL DEALING IN PREMIUMS — EXCESS CHARGES FOR INSURANCE**.

(1) No person shall wilfully collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided (subject to acceptance of the risk by the insurer) by an insurance policy issued by an insurer as authorized by this code.

(2) No person shall wilfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the director; or, in cases where classifications, premiums, or rates are not required by this code to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus line brokers licensed under chapter 12 of this code, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. Nor shall it be deemed to prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section shall be punishable under section 41-117 (general penalty).

**41-1325. BORROWING MONEY FROM CLIENTS.**

(1) An insurance producer who borrows money, securities or anything of value from a client or customer, unless the client or customer is a person engaged in the business of loaning funds or is an immediate family member of the insurance producer, shall complete a written loan agreement that sets forth the parties to the loan, the purpose of the loan, the amount of the loan and the terms of the loan. All parties to the loan must sign the loan agreement acknowledging the transaction and must receive a copy of the loan agreement. The insurance producer shall keep a record of the loan transaction until the loan is paid back in full. Any release of the debt shall be in writing and signed by all parties to the release.

(2) As used in this section, the term "immediate family member" means a parent, mother-in-law, father-in-law, husband, wife, sister, brother, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or a son or daughter.

**41-1327. VIOLATIONS — PENALTY**.

Any person who violates any provision of this chapter as to which a penalty is not expressly provided, or who violates a cease and desist order issued by the director under section 41-213, Idaho Code, after such order has become final, shall be subject to penalties as prescribed by or referred to in section 41-117, Idaho Code (general penalty).

**41-1328. PAYMENT OF CLAIMS BY INSURERS**. Every insurer issuing a motor vehicle insurance policy, as defined in chapter 5, title 41, Idaho Code, shall, in the event of damage to a covered motor vehicle by collision and the election by the insurer to have such motor vehicle repaired, make payment by check or draft, payable to the repairer or to the named insured and the repairer, jointly, no later than twenty (20) days subsequent to receipt of an itemized bill or invoice covering repairs authorized by the insurer which have been satisfactorily completed.

**41-1329. UNFAIR CLAIM SETTLEMENT PRACTICES**.

Pursuant to section 41-1302, Idaho Code, committing or performing any of the following acts or omissions intentionally, or with such frequency as to indicate a general business practice shall be deemed to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement

**41-1329A. UNFAIR CLAIMS SETTLEMENT PRACTICES — PENALTY**.
The director, if he finds after a hearing, that an insurer has violated the provisions of section 41-1329, Idaho Code, may, in his discretion, impose an administrative penalty not to exceed ten thousand dollars ($10,000) to be deposited by the director as provided in section 41-406, Idaho Code, and may, in addition to the fine, or in the alternative to the fine, refuse to continue or suspend or revoke an insurer's certificate of authority.

**41-1803. "PREMIUM" DEFINED**.
"Premium" is the consideration for insurance by whatever name called. Any "assessment," or any "membership," "policy," "survey," "inspection," "service" or similar fee or other charge in consideration for an insurance contract is deemed part of the premium; provided that producer fees charged pursuant to section 41-1030, Idaho Code, shall not be considered a premium unless the fee relates to a surplus line policy.

**41-1806. INSURABLE INTEREST — PROPERTY.**
(1) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.
(2) "Insurable interest" as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.
(3) The measure of an insurable interest in property is the extent to which the insured might be directly damnified by loss, injury, or impairment thereof.

**41-1807. POWER TO CONTRACT — PURCHASE OF INSURANCE BY MINORS.**
(1) Any person of competent legal capacity may contract for insurance.
(2) Any minor not less than fifteen (15) years of age, notwithstanding his minority, may contract for annuities or for insurance upon his own life, body, health, property, liabilities or other interests, or on the person of another in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under (a) any contract for annuity or for insurance upon his own life, body or health, or (b) any contract such minor effected upon his own property, liabilities or other interests, or on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder. Such a minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated, shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract.
(3) Any annuity contract or policy of life or disability insurance procured by or for a minor under subsection (2) above, shall be made payable either to the minor or his estate or to a person having an insurable interest in the life of the minor

**41-1811. REPRESENTATIONS IN APPLICATIONS.**
All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
(a) Fraudulent; or
(b) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
(c) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

**41-1812. FILING, USE AND DISAPPROVAL OF FORMS**.
(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be delivered, or issued for delivery in this state, unless the form has been filed with the director. This provision shall not apply to surety bonds, or to specially rated inland marine risks, nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the director. As to forms for use in property, marine (other than wet marine and transportation insurance), casualty and surety insurance coverages the filing required by this subsection may be made by rating organizations on behalf of its members and subscribers; but this provision shall not be deemed to prohibit any such member or subscriber from filing any such forms on its own behalf.
(2) Every such filing shall be submitted with a certification, in such form as may be determined by the director, by an officer of the insurer that each policy, form, endorsement, or rider in use complies with Idaho law. The director shall have the power to examine such filings to determine whether the policies, forms, endorsements, and riders, as filed, comply with the certification of the insurer and with Idaho law relating to the content of such documents. Upon a determination that any document filed in accordance with this section does not comply with Idaho law, the director shall, in accordance with the Idaho administrative procedure act, prohibit the use of such policy, form, endorsement, rider or other document.
(3) The director may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

**41-1826. ASSIGNMENT OF POLICIES.**
A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or disability policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

**41-1826. ASSIGNMENT OF POLICIES.**
A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or disability policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

**41-1828. PAYMENT DISCHARGES INSURER — PAYMENT TO MARITAL COMMUNITY.**
(1) Whenever the proceeds of or payments under a life or disability insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.
(2) Where the person designated in the policy or contract or by assignment as being entitled thereto is a member of a marital community, whether husband or wife, and the policy or contract is upon the life or disability of either, he or she may receive payment, and shall be and is constituted agent of the marital community with authority to give full acquittance therefor; and such payment to the marital community agent so designated shall fully discharge the insurer from all claims under the policy or contract, but no rights of either member of the marital community, as between themselves, to accounting or division shall be impaired or affected by such payment.

**41-1831. FORMS FOR PROOF OF LOSS TO BE FURNISHED.**
An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

**41-1828. PAYMENT DISCHARGES INSURER — PAYMENT TO MARITAL COMMUNITY.**
(1) Whenever the proceeds of or payments under a life or disability insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.
(2) Where the person designated in the policy or contract or by assignment as being entitled thereto is a member of a marital community, whether husband or wife, and the policy or contract is upon the life or disability of either, he or she may receive payment, and shall be and is constituted agent of the marital community with authority to give full acquittance therefor; and such payment to the marital community agent so designated shall fully discharge the insurer from all claims under the policy or contract, but no rights of either member of the marital community, as between themselves, to accounting or division shall be impaired or affected by such payment.

**41-1850. CERTIFICATES OF INSURANCE**.
(1) For purposes of this section, the following terms have the following meanings:
  (a) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, that is prepared or issued as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance, insurance binder, policy endorsement or automobile insurance identification card.
  (b) "Certificate holder" means any person, other than a policyholder, that requests, obtains or possesses a certificate of insurance.
  (c) "Insurance producer" has the same meaning as provided for in chapter 10, title 41, Idaho Code.
  (d) "Insurer" has the same definition as provided for in section 41-103, Idaho Code.
  (e) "Person" means any individual, partnership, corporation, association or other legal entity, including any government or governmental subdivision or agency.
  (f) "Policyholder" means a person that has contracted with a property or casualty insurer for insurance coverage.
  (g) "Group master policy" means an insurance policy that provides coverage to eligible persons on a group basis through a group insurance program.
(2) No person, wherever located, may prepare, issue or knowingly request the issuance of a certificate of insurance unless the form has been filed with the director by or on behalf of an insurer. No person, wherever located, may alter or modify a certificate of insurance form unless the alteration or modification has been filed with the director.
(3) The director shall disapprove the use of any form filed under this section, or withdraw approval of a form, if the form:
  (a) Is unfair, misleading or deceptive, or violates public policy;
  (b) Fails to comply with the requirements of this section; or
  (c) Violates any provision of title 41, Idaho Code, including any rule promulgated by the director.
(4) Each certificate of insurance must contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend the coverage, terms, exclusions and conditions afforded by the policies referenced herein."
(5) The current edition of standard certificate of insurance forms promulgated and filed with the director by the association for cooperative operations research and development (ACORD) or the insurance services office (ISO) are not required to be refiled by individual insurers.
(6) No person, wherever located, shall demand or request the issuance of a certificate of insurance or other document, record or correspondence that the person knows contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.
(7) No person, wherever located, may knowingly prepare or issue a certificate of insurance or other document, record or correspondence that contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.
(8) The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers and certificate of insurance forms issued as evidence of property or casualty insurance coverages on property, operations or risks located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located.

**41-1850. CERTIFICATES OF INSURANCE (continued).**

(9) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively alter, amend or extend the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance provides.
(10) A certificate of insurance may not warrant that the policy of insurance referenced in the certificate comply with the insurance or indemnification requirements of a contract, and the inclusion of a contract number or description, or project number or description, within a certificate of insurance may not be interpreted as doing such. Notwithstanding any requirement, term or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions and conditions of the policy itself.
(11) A person is entitled to receive notice of cancellation, nonrenewal or any material change or any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy or any endorsement to the policy. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.
(12) Any certificate of insurance or any other document, record or correspondence prepared, issued or requested in violation of this section shall be null and void and of no force and effect.
(13) Any person that violates this section shall be subject to an administrative penalty imposed by the director in an amount as provided for in section 41-117, Idaho Code, per violation.
(14) The director shall have the power to examine and investigate the activities of any person that the director believes has been or is engaged in an act or practice prohibited by this section. The director shall have the power to enforce the provisions of this section and impose any authorized penalty or remedy against any person that violates this section.
(15) The director may, in accordance with section 41-211, Idaho Code, adopt reasonable rules as are necessary or proper to carry out the provisions of this section.
(16) This section shall not apply to any certificate of insurance prepared and/or issued by an insurer pursuant to any federal law, rule or regulation, or any other law, rule or regulation of this state, in which the specific content and form of said certificate is enumerated therein, or a certificate issued to a person or entity that has purchased coverage under a group master policy.

**41-2010. PROVISIONS REQUIRED IN GROUP CONTRACTS.**

No policy of group life insurance shall be delivered in this state unless it contains in substance the provisions set forth in sections 41-2011 through 41-2020 of this chapter or provisions which in the opinion of the director are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; except, however, that:
(1) Sections 41-2016 to 41-2020 inclusive shall not apply to policies issued to a creditor to insure debtors of such creditor;
(2) The standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and
(3) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the director is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

**41-2025. ASSIGNMENT OF INCIDENTS OF OWNERSHIP IN GROUP LIFE INSURANCE POLICIES, INCLUDING CONVERSION PRIVILEGES.**

Nothing in this insurance code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of his incidents of ownership under such policy, including but not limited to the privilege to have issued to him an individual policy of life insurance pursuant and subject to the provisions of sections 41-2018, 41-2019 and 41-2021, Idaho Code, and the right to name a beneficiary. Subject to the terms of the policy or agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership thereunder, such an assignment by an insured, made either before or after the effective date [February 25, 1970] of this act, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with sections 41-2018 and 41-2019, Idaho Code, prior to receipt of notice of the assignment.

**41-2103. SCOPE AND FORMAT OF POLICY.**

No policy of disability insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:
(1) The entire money and other considerations therefor shall be expressed therein;
(2) The time when the insurance takes effect and terminates shall be expressed therein;
(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife and any other dependent or dependents. As used in this subsection (3) and for all new and renewing policies, "dependent" includes an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;
(4) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);
(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in sections 41-2105 through 41-2127, Idaho Code, shall be printed, at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "exceptions," or "exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;
(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;
(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director;
(8) When the policy provides payment for medical or surgical expense to the insured, on a reimbursement basis, or otherwise, the insured shall be entitled to a free choice of medical doctor to perform said services, or the free choice of a podiatrist if the latter is authorized by law to perform the particular medical or surgical services covered under the terms of said policy; and
(9) When the policy provides for payment for the expense of services that are within the lawful scope of practice of a duly licensed optometrist, on a reimbursement basis or otherwise, the insured shall be entitled to a free choice of medical doctor or optometrist to perform such services.

**41-2106. TIME LIMIT ON CERTAIN DEFENSES.**
(1) There shall be a provision as follows:
"Time Limit on Certain Defenses:
(a) After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two (2) year period.
(b) No claim for loss incurred or disability, as defined in the policy, commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."
(2) The policy provision of (1)(a) above shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two (2) year period, nor to limit the application of sections 41-2118 through 41-2122, Idaho Code, in the event of misstatement with respect to age or occupation or other insurance.
(3) Notwithstanding the provisions of section 41-2106(2), Idaho Code, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy must cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.
(4) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty (50) or, (b) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain in lieu of the foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption, "Incontestable":
"After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to any statements, other than fraudulent statements, contained in the application."

**41-2107. GRACE PERIOD.**
There shall be a provision as follows:
"Grace Period: A grace period of….(insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."
A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision:
"Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

**41-2108. REINSTATEMENT.**
(1) There shall be a provision as follows:
"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement."
(2) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums
(a) Until at least age fifty (50), or
(b) In the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.

**41-2138. HEALTH INSURANCE — TEN-DAY FREE EXAMINATION.**
(1) Except as to nonrenewable accident policies and individual credit health insurance policies, every individual health insurance policy shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten (10) days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy under appropriate caption, and if not so printed on the face page of the policy adequate notice of the provision shall be printed or stamped conspicuously on the face page.
(2) The policy may be so returned to the insurer at its home or branch office or to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy had not been issued.

**41-2139. REQUIRED PROVISIONS — COVERAGE OF DEPENDENT CHILD.**
There shall be a provision as follows: a policy delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of this act under which coverage of a dependent of an insured terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of intellectual disability or physical disability and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon such insured for support and maintenance, not so terminate while the policy remains in force and the dependent remains in such condition, if the insured has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year.

**41-2140. REQUIRED PROVISIONS.**
(1) Any disability insurance contract delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of the insured, shall provide such coverage for such newborn children, including adopted newborn children that are placed with the adoptive insured within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive insured more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18)

years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive insured signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with an insured continues in the same manner as it would with respect to a naturally born child of the insured until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the insured rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) An insurer shall not restrict coverage under a disability insurance policy of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs which the participant or beneficiary is eligible for coverage under the plan.

(3) No policy of disability insurance which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the policy. If a fixed amount is specified in such policy for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the policy. Where the policy contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the policy. This section shall apply to all disability policies except individual noncancelable or guaranteed renewable policies, issued or delivered before January 1, 1977. With respect to such individual noncancelable or guaranteed renewable policies issued or delivered before January 1, 1977, the insurer shall communicate the availability of coverage of involuntary complications of pregnancy when negotiating any changes in such policies. For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits, shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

**41-2144. MAMMOGRAPHY COVERAGE.**

(1) From and after July 1, 1992, all disability contracts which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

(a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.

(b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.

(c) A mammogram every year for any woman who is fifty (50) years of age or older.

(d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

**41-2210. REQUIRED PROVISION IN GROUP AND BLANKET POLICIES.**

(1) Any group disability insurance contract or blanket disability insurance contract, delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of subscribers or other members of the covered group, shall provide coverage for such newborn children, including adopted newborn children that are placed with the adoptive subscriber or other member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive subscriber or other member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive subscriber or other member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a subscriber or other member of the covered group continues in the same manner as it would with respect to a naturally born child of the subscriber or other member of the covered group until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the subscriber or other member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) An insurer shall not restrict coverage under a group disability insurance contract or a blanket disability insurance contract of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of a child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

*41-2210. REQUIRED PROVISION IN GROUP AND BLANKET POLICIES (continued).*

(4) No policy of disability insurance which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the policy. If a fixed amount is specified in such policy for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the policy. Where the policy contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the policy. This section shall apply to all disability policies except any group disability policy made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits, shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

**41-2212. DEFINITIONS.**

In this act, unless the context otherwise requires:

(1) "Carrier" shall mean the insurance company, nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a policy.
(2) "Dependent" shall have the meaning set forth in a policy.
(3) "Discontinuance" shall mean the termination of a policy by action taken by the policyholder, including failure to pay premium within the period provided by the policy, or by the carrier pursuant to a provision of the policy permitting termination or by mutual agreement of the policyholder and carrier.
(4) "Employee" shall mean all agents, employees, and members of unions or associations to whom benefits are provided under a policy.
(5) "Extension of Benefits" means the continuation of coverage under a particular benefit provided under a policy following discontinuance with respect to an employee or dependent who is totally disabled on the date of discontinuance.
(6) "Policy" shall mean any group insurance policy, group hospital and medical service contract or other plan, contract or policy subject to the provisions of this act.
(7) "Policyholder" shall mean the entity to which a policy is issued as specified in section 41-2213.
(8) "Premium" shall mean the consideration payable to the carrier.
(9) "Replacement Coverage" shall mean the benefits which are substituted under one carrier's policy by similar benefits under a policy issued by another carrier.
(10) "Totally Disabled" shall have the meaning set forth in a policy and not be inconsistent with the definition of "disability insurance" in section 41-503, Idaho Code.

**41-2218. MAMMOGRAPHY COVERAGE.**

(1) From and after July 1, 1992, all group or blanket disability insurance policies which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:
    (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
    (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
    (c) A mammogram every year for any woman who is fifty (50) years of age or older.
    (d) A mammogram for any woman desiring a mammogram for medical cause.

    Such coverage shall not exceed the cost of the examination.
(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.
(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies

**41-2221. CREDITING OF PREEXISTING CONDITION WAITING PERIOD.**

(1) Health benefit plans covering large employers shall comply with the following provisions:
    (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 a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.
    (b) Genetic information shall not be considered as a condition described in subsection (1)(a) of this section in the absence of a diagnosis of the condition related to such information.
    (c) 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 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.
    (d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.

*41-2221. CREDITING OF PREEXISTING CONDITION WAITING PERIOD. (continued)*

(2) As used in this section:

(a) "Health benefit plan" means any group hospital or medical policy or certificate, any group subscriber contract provided by a hospital or professional service corporation, or group health maintenance organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(b) "Large employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no less than fifty-one (51) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(c) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a large employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(i) The individual meets each of the following:

a. The individual was covered under qualifying previous coverage at the time of the initial enrollment;

b. The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage; and

c. The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(ii) The individual is employed by a large employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(iii) A court has ordered coverage be provided for a spouse or a minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order; or

(iv) The individual first becomes eligible.

(d) "Qualifying previous coverage" and "qualifying existing coverage" means benefits or coverage provided under:

(i) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefits risk pool, or any other similar publicly sponsored program; or

(ii) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

**41-2303. SCOPE OF CHAPTER**.

All life insurance and all disability insurance in connection with loans or other credit transactions shall be subject to the provisions of this chapter; except, that insurance in connection with a loan or other credit transaction of more than fifteen (15) years duration shall not be subject to this chapter, nor shall insurance be subject to this chapter where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

**41-2902. "RECIPROCAL INSURER" DEFINED.**

A "reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney in fact to provide reciprocal insurance among themselves. When all participants in a reciprocal insurer are political subdivisions of the state of Idaho, such interexchange may be accomplished by a joint exercise of powers agreement pursuant to chapter 23, title 67, Idaho Code.

**41-2304. DEFINITIONS**.

For the purposes of this chapter:

(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(2) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(3) "Creditor" means the lender of money or vendor of goods, services or property, including a lessor under a lease intended as a security, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender or vendor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them.

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

**41-2305. FORMS OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE**.

Credit life insurance and credit disability insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan.

(2) Individual policies of disability insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance.

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan.

(4) Group policies of disability insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage.

**41-2307. TERM OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE**.
The term of any credit life insurance or credit disability insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 41-2310

**41-2311. ISSUANCE OF POLICIES**.
All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the director.

**41-3201. FRATERNAL BENEFIT SOCIETIES.**
Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of section 41-3237(1)(b), Idaho Code, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

**41-3210. ORGANIZATION**.
A domestic society organized on or after the effective date of this act shall be formed as follows:

(1) Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:
   (a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;
   (b) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted in this chapter;
   (c) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

(2) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the director, who may require such further information as the director deems necessary. The bond with sureties approved by the director shall be in such amount, not less than three hundred thousand dollars ($300,000), nor more than one million five hundred thousand dollars ($1,500,000), as required by the director. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the director shall so certify, retain and file the articles of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the director upon cause shown, unless the five hundred (500) applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(4) Upon receipt of a preliminary certificate of authority from the director, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:
   (a) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;
   (b) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;
   (c) There has been submitted to the director, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and
   (d) It shall have been shown to the director, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars ($150,000). Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, as herein provided, such premiums shall be returned to said applicants.

(5) The director may make such examination and require such further information as the director deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the director shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The director shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this state at the time this act becomes effective shall not be required to reincorporate.

**41-3438. COMPLICATIONS OF PREGNANCY.**

No hospital or medical service corporation contract which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the contract. If a fixed amount is specified in such contract for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the contract. Where the contract contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the contract. This section shall apply to all hospital or medical service corporation contracts except any group hospital or medical service corporation contract made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such contract which is in conflict with this section shall be of no force or effect.

**41-4023. COVERAGE FROM MOMENT OF BIRTH — COMPLICATIONS OF PREGNANCY.**

(1) Every self-funded plan issued pursuant to this chapter in this state, or providing coverage to any covered family residing within this state, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

(a) The date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the covered family rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn or adopted children or infants of a covered family, which child or children are covered from and after the moment of birth that is inconsistent with the provisions of this section.

(2) Neither the plan trustee or employer or a postsecondary educational institution nor an insurer shall restrict coverage under a self-funded plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) No self-funded plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan. This subsection shall apply to all self-funded plans except any such plan made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this subsection, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subsection and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no self-funded plan that provides maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

(5) Any new or renewing self-funded group disability plan or blanket disability plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-six (26) years shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

**41-4201. PURPOSE.**

The purpose of this act shall be to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of nonprofit hospitals, medical and dental service associations, and nongroup subscriber contracts of managed care organizations to facilitate public understanding and comparison, to eliminate provisions contained in individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts of managed care organizations which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of disability coverages.

**41-4202. DEFINITIONS.**

(1) "Form" includes but is not limited to policies, contracts, certificates, riders, endorsements, and applications as provided in sections 41-1812, 41-3419 and 41-3915, Idaho Code.

(2) "Disability Insurance" means insurance written under chapter 21, title 41, Idaho Code, supplemental disability insurance written under chapter 22, title 41, Idaho Code, coverages written under chapter 34, title 41, Idaho Code, and coverages written under chapter 39, title 41, Idaho Code. For purposes of this act, nonprofit hospital, medical and dental service associations, and managed care organizations shall be deemed to be engaged in the business of insurance.

(3) "Policy" means the entire contract between the insurer and the insured, including the policy, certificates, riders, endorsements, and the application, if attached, and also includes nongroup subscriber contracts issued by nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts issued by managed care organizations.

**41-4203. STANDARDS FOR POLICY PROVISIONS.**

(1) The director shall issue rules, subject to chapter 52, title 67, Idaho Code, to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of disability insurance, group supplemental policies of disability insurance, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations and nongroup subscriber contracts of managed care organizations which shall be in addition to and in accordance with applicable laws of this state, which may cover but shall not be limited to:

(a) Terms or renewability;
(b) Initial and subsequent conditions of eligibility;
(c) Nonduplication of coverage provisions;
(d) Coverage of dependents;
(e) Pre-existing conditions;
(f) Termination of insurance;
(g) Probationary periods;
(h) Limitations;
(i) Exceptions;
(j) Reductions;
(k) Elimination periods;
(l) Requirements for replacement;
(m) Recurrent conditions; and
(n) The definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancelable.

(2) The director may issue rules that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the director are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

**41-4204. MINIMUM STANDARDS FOR BENEFITS.**

(1) The director shall issue rules, subject to chapter 52, title 67, Idaho Code, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, group supplemental policies, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts of managed care organizations other than conversion policies issued pursuant to a contractual conversion privilege under a group policy of disability insurance:

(a) Basic hospital expense coverage;
(b) Basic medical-surgical and dental expense coverage;
(c) Hospital confinement indemnity coverage;
(d) Major medical expense coverage;
(e) Disability income protection coverage;
(f) Accident only coverage; and
(g) Specified disease.

(2) Nothing in this section shall preclude the issuance of any policy or contract which combines two (2) or more of the categories of coverage enumerated in paragraphs (a) through (g) of subsection (1) of this section.

(3) No policy or contract shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in paragraphs (a) through (g) of subsection (1) of this section, which are contained within the policy or contract unless the director finds such policy or contract will be in the public interest and such policy or contract meets the requirements set forth in section 41-1813, Idaho Code.

(4) The director shall prescribe the method of identification of policies and contracts based upon coverages provided.

**41-4205. OUTLINE OF COVERAGE.**

(1) In order to provide for full and fair disclosure in the sale of individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of a nonprofit hospital, medical or dental service association, or nongroup subscriber contracts of managed care organizations, no such policy or contract shall be offered, delivered, issued for delivery, continued or renewed in this state unless:

(a) In the case of a direct response insurance product, the outline of coverage described in subsection (2) of this section accompanies the policy;
(b) In all other cases, the outline of coverage described in subsection (2) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt of certificate of delivery of such outline is provided the insurer with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and clearly state that it is not the policy or contract for which application was made.

(2) The director shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in section 41-4204, Idaho Code;
(b) A description of the principal benefits and coverage provided in the policy or contract;
(c) A statement of the exceptions, reductions and limitations contained in the policy or contract;
(d) A statement of the renewal provisions including any reservation by the insurer, nonprofit hospital, medical or dental service association or managed care organization of a right to change premiums;
(e) A statement that the outline is a summary of the policy, certificate or contract issued or applied for and that the policy, certificate or contract should be consulted to determine governing contractual provisions.

**41-4206– No longer exists**

**41-4301. SHORT TITLE.**
This chapter shall be known and may be cited as the "Idaho Life and Health Insurance Guaranty Association Act."

**41-4302. PURPOSE.**
(1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in section 41-4303(1), Idaho Code, against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in section 41-4303(2), Idaho Code, because of the impairment or insolvency of the member insurer that issued the policies or contracts.
(2) To provide the protection stated in subsection (1) of this section, an association of insurers will pay benefits and continue coverages as provided for and limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

**41-4303. COVERAGE AND LIMITATIONS.**
(1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) of this section:
(a) To persons, except for nonresident certificate holders under group policies or contracts who, regardless of where they reside, are the beneficiaries, assignees or payees of the persons covered under paragraph (b) of this subsection.
(b) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:
(i) Are residents; or
(ii) Are not residents, but only under all of the following conditions:
1. The insurer that issued the policies or contracts is domiciled in this state;
2. The states in which the persons reside have associations similar to the association created by this chapter; and
3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.
(c) For structured settlement annuities specified in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (d) and (e) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:
(i) Is a resident, regardless of where the contract owner resides; or
(ii) Is not a resident, but only under both of the following conditions:
1. (A) The contract owner of the structured settlement annuity is a resident; or
(B) The contract owner of the structured settlement annuity is not a resident; but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created in this chapter; and
2. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.
(d) The provisions of this chapter shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.
(e) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, the provisions of this chapter shall be construed in conjunction with other state laws to result in coverage by only one (1) association.
(2) (a) The provisions of this chapter shall provide coverage to the persons specified in subsection (1) of this section for direct, non group life, health or annuity policies or contracts and for certificates under direct group policies and contracts and for supplemental contracts to any of these, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.
(b) The provisions of this chapter shall not provide coverage for:
(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;
(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;
(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier; and
2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;
(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured including, but not limited to, benefits payable by an employer, association or other person under:
1. A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974, 29 U.S.C. section 1002(40);
2. A minimum premium group insurance plan;
3. A stop-loss group insurance plan; or
4. An administrative services only contract;
(v) A portion of a policy or contract to the extent that it provides for:
1. Dividends or experience rating credits;
2. Voting rights; or
3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;
(vii) A portion of a policy or contract to the extent that the assessments required in section 41-4309, Idaho Code, with respect to the policy or contract are preempted by federal or state law;

**41-4304. CONSTRUCTION**.
The provisions of this chapter shall be construed to effect the purpose under section 41-4302, Idaho Code.

**41-4305. DEFINITIONS.**
As used in this chapter:

(1) "Account" means any of the three (3) accounts maintained pursuant to section 41-4306, Idaho Code.
(2) "Association" means the Idaho life and health insurance guaranty association.
(3) "Authorized assessment" or "authorized," when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.
(4) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.
(5) "Called assessment" or "called," when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.
(6) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 41-4303, Idaho Code.
(7) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under section 41-4303, Idaho Code.
(8) "Director" means the director of the Idaho department of insurance.
(9) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.
(10) "Impaired insurer" means a member insurer:
    (a) Deemed by the director after the effective date of this chapter to be potentially unable to fulfill its contractual obligations and not an insolvent insurer; or
    (b) Which, after the effective date of this chapter, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
(11) "Insolvent insurer" means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
(12) (a) "Major medical insurance" means, solely for purposes of this chapter, health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.
    (b) "Major medical insurance" shall not include insurance policies, contracts or certificates:
        (i) Issued by an insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance or specified disease or hospital confinement indemnity insurance; or
        (ii) For medicare supplement insurance or for coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (CHAMPUS).
(13) (a) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 41-4303, Idaho Code, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn.
    (b) "Member insurer" does not include:
        (i) A hospital or medical service corporation or organization, whether profit or nonprofit;
        (ii) A fraternal benefit society;
        (iii) A mandatory state pooling plan;
        (iv) A mutual assessment company or other person that operates on an assessment basis;
        (v) An insurance exchange;
        (vi) An organization that issues charitable gift annuities under section 41-120, Idaho Code;
        (vii) A mutual benefit association;
        (viii) A reciprocal insurer;
        (ix) A limited managed care plan;
        (x) A self-funded health care plan; or
        (xi) A consumer operated and oriented plan established under section 1322 of the patient protection and affordable care act, P.L. 111-148.
(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto.
(15) "Owner," "policy owner" or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.
(16) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.
(17) (a) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.
    (b) "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 41-4303(2), Idaho Code, except that assessable premium shall not be reduced on account of section 41-4303(2)(b)(iii), Idaho Code, relating to interest limitations and section 41-4303(3)(b), (c) and (d), Idaho Code, relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:
        (i) Premiums on an unallocated annuity contract; or
        (ii) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

*41-4305. DEFINITIONS. (continued)*

(18) (a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;
(ii) The state in which the principal office of the chief executive officer of the entity is located;
(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
(v) The state from which the management of the overall operations of the entity is directed; and
(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors contained in subparagraphs (i) through (v) of this paragraph. However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) "Principal place of business" of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(20) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created in this chapter, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "State" means a state or a commonwealth of the United States, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(22) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(24) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

**41-4306. CREATION OF THE ASSOCIATION.**

(1) This chapter continues the existence of the nonprofit legal entity known as the Idaho life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 41-4310, Idaho Code, and shall exercise its powers through a board of directors provided for under section 41-4307, Idaho Code. For purposes of administration and assessment, the association shall continue the existence and maintenance of three (3) accounts:

(a) Life insurance account;
(b) Health insurance account, formerly designated the "disability insurance account"; and
(c) Annuity account.

(2) The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

**41-4307. BOARD OF DIRECTORS**.

(1) The board of directors of the association shall consist of not fewer than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board of directors shall be selected by member insurers subject to the approval of the director. Vacancies on the board of directors shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director.

(2) In approving selections, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board of directors shall not otherwise be compensated by the association for their services.

**41-4308. POWERS AND DUTIES OF THE ASSOCIATION.**

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; and

(b) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

***41-4308. POWERS AND DUTIES OF THE ASSOCIATION (continued).***

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a) (i) 1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination, pursuant to subparagraph (i) of this paragraph, of the benefits provided;

(iii) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv) of this paragraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

(iv) 1. In providing the substitute coverage required under subparagraph (iii) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy; and

3. The association may reinsure any alternative or reissued policy;

(v) 1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten; and

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under this paragraph (b) of this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 41-4303(2)(b)(iii), Idaho Code.

(c) With respect to health benefit plans that are subject to state or federal guaranteed issue requirements, the association may terminate the policies upon entry of an order of liquidation with approval of the director.

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:
   (a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or
   (b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to chapter 8, title 41, Idaho Code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11) (a) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require a written instrument of assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.
   (b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.
   (c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code, section 130.
   (d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.
   (e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (a) through (d) of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:
   (a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;
   (b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 41-4309, Idaho Code, and to settle claims or potential claims against it;
   (c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;
   (d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;
   (e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;
   (f) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;
   (g) Reorganize itself with the prior written approval of the director from a nonprofit association into a corporation or other legal form of nonprofit entity permitted by the laws of the state of Idaho;

**41-4309. ASSESSMENTS.**

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board of directors finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 41-4308, Idaho Code, with regard to an impaired or an insolvent insurer.

(3) (a) The amount of a class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. The total of all non-pro rata assessments shall not exceed three hundred dollars ($300) per member insurer in any one (1) calendar year.

(b) The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of a class B assessment for long-term care insurance shall be allocated according to a methodology selected by the association and approved by the director, which methodology shall provide for fifty percent (50%) of the assessment to be allocated to health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under this subsection and subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5) (a) The total of all class B assessments authorized by the association with respect to a member insurer for each account shall not in one (1) calendar year exceed two percent (2%) of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in an account, does not provide in any one (1) year in an account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments.

A reasonable amount, as determined by the board of directors in its discretion, may be retained by the association in any account to provide funds for the continuing and future expenses of the association and for future loss claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the director for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9) (a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with the request.

**41-3611. SUBROGATION OF ASSOCIATION TO RIGHTS OF CLAIMANTS — RECEIVER, LIQUIDATOR, OR SUCCESSOR BOUND BY ASSOCIATION CLAIM SETTLEMENTS — PERIODIC FILING OF STATEMENTS OF PAID CLAIMS WITH RECEIVER OR LIQUIDATOR.**

(1) Any person recovering under this act shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this act shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of claims made by the association or a similar organization in another state to the extent such determinations or settlements satisfy obligations of the association. The receiver shall not be bound in any way by such determinations or settlements to the extent there remains a claim against the insolvent insurer. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this act against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

**41-3926. MAMMOGRAPHY COVERAGE.**

(1) From and after July 1, 1992, all policies, contracts, plans or certificates issued by an organization offering a managed care plan which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:
   (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
   (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
   (c) A mammogram every year for any woman who is fifty (50) years of age or older.
   (d) A mammogram for any woman desiring a mammogram for medical cause.
   Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

**41-3932. EXEMPTIONS FROM APPLICATION OF CHAPTER.**

This chapter shall not apply to managed care programs operated under contract with the federal government under title XVIII of the federal social security act, as amended (medicare), or under contract with a plan otherwise exempt from operation of this chapter pursuant to the employee retirement income security act of 1974, as amended (ERISA). This chapter shall not apply to programs administered by the department of health and welfare under contract with the department of health and welfare under title XIX of the federal social security act, as amended (medicaid) or under programs administered by the department of health and welfare substance use disorder bureau or its contracted managed care organization.

**41-4310. PLAN OF OPERATION.**

(1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty (30) days.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:
   (a) Establish procedures for handling the assets of the association;
   (b) Establish the amount and method of reimbursing members of the board of directors under section 41-4307, Idaho Code;
   (c) Establish regular places and times for meetings including telephone conference calls of the board of directors;
   (d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;
   (e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;
   (f) Establish any additional procedures for assessments under section 41-4309, Idaho Code; and
   (g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under section 41-4308(12)(c), Idaho Code, and section 41-4309, Idaho Code, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the associ-

**41-4402. DEFINITIONS.**

(1) "Applicant" means:
   (a) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and
   (b) In the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means, for the purposes of this chapter, any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, managed care organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(5) "Medicare" means the "Health Insurance for the Aged Act," title XVIII of the social security amendments of 1965, as then constituted or later amended.

(6) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or an enrollee contract under a managed care organization, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 U.S.C. section 1395 et seq.), or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

(7) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

**41-4403. APPLICABILITY AND SCOPE.**

(1) Except as otherwise specifically provided this chapter shall apply to:

(a) All medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this act; and

(b) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(2) This chapter shall not apply to a policy of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) Except as otherwise specifically provided in section 41-4406(4), Idaho Code, the provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons when the policies are not marketed or held to be medicare supplement policies or benefit plans.

(1) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The director may prescribe the format and content of the outline of coverage required by this section. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums;

(c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The director may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the director may require by rule that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the director may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event later than the time of policy delivery.

(4) The director may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(5) The director may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, or certificates by persons eligible for medicare.

**41-4407. NOTICE OF FREE EXAMINATION.**

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

**41-4408. FILING REQUIREMENTS FOR ADVERTISING.**

Every issuer of medicare supplement insurance policies or certificates in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the director of the Idaho department of insurance for review or approval by the director to the extent it may be required under state law.

**41-4603. DEFINITIONS.**

Unless the context requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means, for the purposes of this chapter, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Director" means the director of the department of insurance of this state.

(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organizations; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one (1) or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the director that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one (1) year; and have a constitution and bylaws which provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees unless the director makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(5) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, managed care organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter.

(6) "Policy" means, for the purposes of this chapter, any policy, contract, enrolled member agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, managed care organization, or any similar organization.

**41-4605. DISCLOSURE AND PERFORMANCE STANDARDS FOR LONG-TERM CARE INSURANCE.**

(1) The director may adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(2) No long-term care insurance policy may:

(a) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(3) Preexisting condition:

(a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in section 41-4603(4)(a), Idaho Code, shall use a definition of "preexisting condition" which is more restrictive than the following: preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in section 41-4603(4)(a), Idaho Code, may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(c) The director may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (3)(b) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (3)(b) of this section.

(4) Prior hospitalization/institutionalization:

(a) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(i) Conditions eligibility for any benefits on a prior hospitalization requirement;

(ii) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(iii) Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

(b) (i) A long-term care insurance policy containing postconfinement, postacute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" such limitations or conditions, including any required number of days of confinement.

(ii) A long-term care insurance policy or rider which conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(iii) A long-term care insurance policy or rider containing a benefit advertised, marketed, or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

(5) The director may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

(6) Right to return — Free look: Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section 41-4603(4)(a), Idaho Code, the applicant is not satisfied for any reason.

*41-4605. DISCLOSURE AND PERFORMANCE STANDARDS FOR LONG-TERM CARE INSURANCE (continued).*

(7) (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(i) The director shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(ii) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(iii) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(iv) In the case of a policy issued to a group defined in section 41-4603(4)(a), Idaho Code, an outline of coverage shall not be required to be delivered, provided that the information described in paragraphs (b)(i) through (b)(vi) of this subsection is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the director.

(b) The outline of coverage shall include:

(i) A description of the principal benefits and coverage provided in the policy;

(ii) A statement of the principal exclusions, reductions and limitations contained in the policy;

(iii) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(iv) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(v) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(vi) A brief description of the relationship of cost of care and benefits.

(8) A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(9) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits for long-term care;

(d) A statement that any long-term care inflation protection option as defined by the long-term care insurance rule is not available under this policy.

(e) If applicable to the policy type, the summary shall also include:

(i) A disclosure of the effects of exercising other rights under the policy;

(ii) A disclosure of guarantees related to long-term care costs of insurance charges;

(iii) Current and projected maximum lifetime benefits.

(10) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(a) Any long-term care benefits paid out during the month;

(b) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(c) The amount of long-term care benefits existing or remaining.

(11) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this chapter.

**41-4701. SHORT TITLE.**

This chapter shall be known and may be cited as the "Small Employer Health Insurance Availability Act."

**41-4702. PURPOSE**.

The purpose and intent of this chapter is to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

**41-4703. DEFINITIONS.**

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 41-4706, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

**41-4703. DEFINITIONS (continued).**

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.
(5) "Board" means the board of directors of the small employer reinsurance program and the individual high risk reinsurance pool as provided for in section 41-5502, Idaho Code.
(6) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.
(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.
(8) "Catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.
(9) "Class of business" means all or a separate grouping of small employers established pursuant to section 41-4705, Idaho Code.
(10) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.
(11) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
(12) "Director" means the director of the department of insurance of the state of Idaho.
(13) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty (20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.
(14) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
(15) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issues for a period of twelve (12) months or less.
(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.
(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:
    (a) The individual meets each of the following:
        (i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;
        (ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and
        (iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.
    (b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.
    (c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.
    (d) The individual first becomes eligible.
    (e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:
        (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
        (ii) In the case of a dependent's birth, as of the date of such birth; or
        (iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.
(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.
(19) "Plan of operation" means the plan of operation of the program established pursuant to section 41-4711, Idaho Code.
(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:
    (a) The deductible/limit year used under the plan;
    (b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
    (c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or
    (d) In any other case, the plan year is the calendar year.
(21) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(22) "Program" means the Idaho small employer reinsurance program created in section 41-4711, Idaho Code.
(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:
(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool or any other similar publicly sponsored program; or
(b) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.
(24) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.
(25) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to section 41-4711, Idaho Code.
(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.
(27) "Risk-assuming carrier" means a small employer carrier whose application is approved by the director pursuant to section 41-4710, Idaho Code.
(28) "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.
(29) "Small employer basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 41-4712, Idaho Code.
(30) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.
(31) "Small employer catastrophic health benefit plan" means a higher limit health benefit plan developed pursuant to section 41-4712, Idaho Code.
(32) "Small employer standard health benefit plan" means a health benefit plan developed pursuant to section 41-4712, Idaho Code.

**41-4704. APPLICABILITY AND SCOPE.**
With the exception of a health benefit plan subject to regulation under chapter 52, title 41, Idaho Code, and to the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to the employees of a small employer in this state if any of the following conditions are met:
(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;
(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;
(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 of the United States internal revenue code.
(4) (a) Except as provided in subsection (b) of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one (1) carrier.
(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.
(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510 and 41-511, Idaho Code, shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to small employers in this state.

**41-4705. ESTABLISHMENT OF CLASSES OF BUSINESS.**
(1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:
(a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;
(b) The small employer carrier has acquired a class of business from another small employer carrier; or
(c) The small employer carrier provides coverage to one (1) or more association groups that meet the requirements of section 41-2202, Idaho Code.
(2) A small employer carrier may establish up to nine (9) separate classes of business under the provisions of subsection (1) of this section.
(3) The director may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with the provisions of subsection (2) of this section in the instance of acquisition of an additional class of business from another small

**41-4706. RESTRICTIONS RELATING TO PREMIUM RATES.**

(1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section 41-4711, Idaho Code, or chapter 55, title 41, Idaho Code.

(f) (i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(h) The small employer carrier shall not use case characteristics, other than age, individual tobacco use, geography, as defined by rule of the director, or gender, without prior approval of the director.

(i) A small employer carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(j) The director may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including rules that:

(i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(ii) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(iii) Prescribe the manner in which a small employer carrier is to demonstrate compliance with the provisions of this section, including requirements that a small employer carrier provide the director with actuarial certification as to such compliance.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more small employers included within a class of business of a small employer carrier for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

**41-4708. AVAILABILITY OF COVERAGE — PREEXISTING CONDITIONS — PORTABILITY.**
(1) Every small employer carrier shall, as a condition of offering health benefit plans in this state to small employers, actively offer to small employers all benefit plans, including the small employer basic health benefit plan, the small employer standard health benefit plan, and the small employer catastrophic health benefit plan.
(2) (a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the small employer basic, standard and catastrophic health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.
(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic, standard or catastrophic health benefit plan on the grounds that the plan does not meet the requirements of this chapter.
(3) Health benefit plans covering small employers shall comply with the following provisions:
(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 a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.
(b) Genetic information shall not be considered as a condition described in this subsection in the absence of a diagnosis of the condition related to such information.
(c) 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 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.
(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.
(e) (i) Except as provided in paragraph (e)(iv) of this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.
(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.
(iii) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.
(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.
(f) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (d) of this subsection.
(ii) A small employer carrier shall not modify a basic, standard or catastrophic health benefit plan with respect to a small employer or any eligible emp

**41-5201. SHORT TITLE.**
This chapter shall be known and may be cited as the "Individual Health Insurance Availability Act."

**41-5202. PURPOSE.**
The purpose and intent of this chapter is to promote the availability of health insurance coverage to persons not covered by employment based insurance regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, and to improve the overall fairness and efficiency of the individual health insurance market.

**41-5203. DEFINITIONS.**
As used in this chapter:
(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that an individual carrier is in compliance with the provisions of section 41-5206, Idaho Code, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.
(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
(3) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.
(4) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage.
(5) "Carrier" means any entity that provides health insurance in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

***41-5203. DEFINITIONS (continued).***

(6) "Case characteristics" means demographic or other objective characteristics of an individual that are considered by the individual carrier in the determination of premium rates for the individual, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.
(7) "Control" shall be defined in the same manner as in section 41-3802(2), Idaho Code.
(8) "Dependent" in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
(9) "Director" means the director of the department of insurance of the state of Idaho.
(10) "Eligible individual" means an Idaho resident individual or dependent of an Idaho resident:
(a) Who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or
(b) Who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996, Public Law 104-191, Sec. 2741(b) (HIPAA)).
An "eligible individual" can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of title 41, Idaho Code.
(11) "Enhanced short-term plan" means an individual health benefit plan that:
(a) Has an initial period of less than twelve (12) months and is renewable at the option of the individual for up to the number of months established by rules issued pursuant to section 41-5214, Idaho Code; and
(b) Otherwise meets the standards established by rules issued pursuant to section 41-5214, Idaho Code.
(12) "Established geographic service area" means a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
(13) "Health benefit plan" means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract and includes enhanced short-term plans. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.
(14) "Index rate" means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.
(15) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.
(16) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.
(17) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.
(18) "Individual catastrophic B health benefit plan" means a health benefit plan with limits higher than an individual catastrophic A health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.
(19) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.
(20) "Individual standard health benefit plan" means a health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.
(21) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the individual carrier to individuals with similar case characteristics for newly issued health benefit plans with the same or similar coverage.
(22) "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.
(23) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:
(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or
(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.
(24) "Rating period" means the calendar period for which premium rates established by a carrier are assumed to be in effect.
(25) "Reinsuring carrier" means a carrier participating in the Idaho individual high-risk reinsurance pool established in chapter 55, title 41, Idaho Code.
(26) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.
(27) "Risk-assuming carrier" means a carrier whose application is approved by the director pursuant to section 41-5210, Idaho Code.

**41-5204. APPLICABILITY AND SCOPE.**
To the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to eligible individuals or their dependents if not otherwise subject to the provisions of chapter 22, 40, 47 or 55, title 41, Idaho Code.

(1) Except as provided in subsection (2) of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to individuals in this state by such affiliated carriers were insured by one (1) carrier.

(2) An affiliated carrier that is a managed care organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, an individual carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to individuals in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510, 41-511 and 41-515, Idaho Code, shall apply if an individual carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to individuals in this state.

**41-5206. RESTRICTIONS RELATING TO PREMIUM RATES.**
(1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The premium rates charged during a rating period to individuals with similar case characteristics for the same or similar coverage, or the rates that could be charged to such individuals under the rating system, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(b) The percentage increase in the premium rate charged to an individual for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the individual carrier is no longer enrolling new individuals, the individual carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the individual carrier is actively enrolling new individuals.

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the individual or dependents as determined from the individual carrier's rate manual; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the individual carrier's rate manual.

(c) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by carriers pursuant to section 41-4711, Idaho Code, or chapter 55, title 41, Idaho Code.

(d) (i) Individual carriers shall apply rating factors, including case characteristics, consistently with respect to all individuals. Rating factors shall produce premiums for identical individuals which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the individuals assumed to select particular health benefit plans; and

(ii) An individual carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(f) The individual carrier shall not use case characteristics, other than age, individual tobacco use, geography as defined by rule of the director, or gender, without prior approval of the director.

(g) An individual carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(h) The director may establish rules to implement the provisions of this section and to assure that rating practices used by individual carriers are consistent with the purposes of this chapter, including rules that:

(i) Assure that differences in rates charged for health benefit plans by individual carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit plans;

(ii) Prescribe the manner in which case characteristics may be used by individual carriers; and

(iii) Prescribe the manner in which an individual carrier is to demonstrate compliance with the provisions of this section, including requirements that an individual carrier provide the director with actuarial certification as to such compliance.

(2) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more individuals for one (1) or more rating periods upon a filing by the individual carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the individual carrier or that the suspension would enhance the efficiency and fairness of the marketplace for individual health insurance.

(3) In connection with the offering for sale of any health benefit plan to an individual, an individual carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for an individual are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the individual and his dependents;

(b) The provisions of the health benefit plan concerning the individual carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(4) (a) Each individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each individual carrier shall file with the director annually on or before September 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the individual carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the individual carrier at its principal place of business.

(c) An individual carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the individual carrier or as ordered by a court of competent jurisdiction.

**41-5207. RENEWABILITY OF COVERAGE.**

(1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to the individual or dependents, at the option of the individual, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or intentional misrepresentation of material fact by the individual insured or his representatives. An individual whose coverage is terminated for fraud or misrepresentation shall not be deemed to be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual's coverage and shall not be deemed to have "qualifying previous coverage" under chapter 22, 47 or 52, title 41, Idaho Code;

(c) The individual ceases to be an eligible individual as defined in section 41-5203(10), Idaho Code;

(d) In the case of health benefit plans that are made available in the individual market only through one (1) or more associations, as defined in section 41-2202, Idaho Code, the membership of an individual in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;

(e) The individual carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to individuals in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of individuals and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:

(i) Provide advance written or electronic notice of its decision under this paragraph to the director;

(ii) Provide notice of the discontinuation to all affected individuals at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected individuals;

(iii) Offer to each affected individual, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to individuals in this state;

(iv) Act uniformly without regard to any health status-related factor of an affected individual or dependent of an affected individual who may become eligible for the coverage; and

(v) Offer the new products at rates that comply with section 41-5206(1)(b), Idaho Code.

(f) The individual carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in this state. In such a case the carrier shall:

(i) Provide advance notice of its decision under this paragraph to the director; and

(ii) Provide notice of the decision not to renew coverage to all affected individuals and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected individuals;

(g) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance, the director shall assist affected individuals in finding replacement coverage; or

(h) The plan is an enhanced short-term plan that has reached the limit of renewability established in rules issued by the director and the individual carrier offers the individual the opportunity to reapply for coverage in accordance with the rules issued by the director.

(2) An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(f) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of an individual carrier doing business in one (1) established geographic service area of the state, the rules set forth in

**41-5208. AVAILABILITY OF COVERAGE — PREEXISTING CONDITIONS — PORTABILITY.**

(1) (a) Every individual carrier shall, as a condition of offering health benefit plans in this state to individuals, actively offer health benefit plans to individuals, including the individual basic health benefit plan, the individual standard and the individual HSA compatible health benefit plan.

(b) An individual carrier shall issue an individual basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan to any eligible individual that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the provisions of this chapter.

(2) (a) An individual carrier shall file with the director, in a format and manner prescribed by the director, the basic, standard, catastrophic, and HSA compatible health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by an individual carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the individual carrier, disapprove the continued use by an individual carrier of a basic, standard, catastrophic, or HSA compatible health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering eligible individuals shall comply with the following provisions:

(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:

(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;

(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

(iii) A pregnancy existing on the effective date of coverage.

(b) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by qualifying previous coverage, 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. As provided in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)), with regard to federally eligible individuals under HIPAA, any limitation or exclusion of benefits relating to a condition based on the fact that

**41-5209. NOTICE OF INTENT TO OPERATE AS A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.**

(1) (a) Each individual carrier shall notify the director within thirty (30) days of the effective date of this chapter of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. An individual carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of section 41-5210, Idaho Code.

(b) The decision shall be binding for a five (5) year period except that the initial decision shall be binding for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for individual carriers seeking to change their status under the provisions of this subsection.

(2) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

**41-5210. APPLICATION TO BECOME A RISK-ASSUMING CARRIER.**

(1) An individual carrier may apply to become a risk-assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(2) The director shall consider the following factors in evaluating an application filed under the provisions of subsection (1) of this section:

(a) The carrier's financial condition;

(b) The carrier's history of rating and underwriting individuals;

(c) The carrier's commitment to market fairly to all individuals in the state or its established geographic service area, as applicable;

(d) The carrier's experience with managing the risk of individuals; and

(e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (3) of section 41-5204, Idaho Code.

(3) The director shall provide public notice of an application by an individual carrier to be a risk-assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(4) The director may rescind the approval granted to a risk-assuming carrier under the provisions of this section if the director finds that:

(a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to individuals in compliance with the provisions of section 41-5208, Idaho Code, without the protection afforded by the program;

(b) The carrier has failed to market fairly to all individuals in the state or its established geographic service area, as applicable; or

(c) The carrier has failed to provide coverage to eligible individuals as required in section 41-5208, Idaho Code.

(5) An individual carrier electing to be a risk-assuming carrier shall not be subject to the provisions of section 41-4711, Idaho Code, except to the extent such individual carrier is subject to assessment for additional funding pursuant to the provisions of subsection

**41-5211. ADMINISTRATIVE PROCEDURES.**

The director shall promulgate rules in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the individual health coverage reform act.

**41-5212. STANDARDS TO ASSURE FAIR MARKETING.**

(1) Each individual carrier shall actively market health benefit plan coverage, including the individual basic, standard, catastrophic A, catastrophic B, and HSA compatible health benefit plans, to eligible individuals in the state. If an individual carrier denies coverage to an individual on the basis of the health status or claims experience of the individual or dependents, the individual carrier shall offer the individual the opportunity to purchase an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(2) (a) Except as provided in subsection (2)(b) of this section, no individual carrier or agent shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing individuals to refrain from filing an application for coverage with the individual carrier because of the health status, claims experience, industry, occupation or geographic location of the individual or dependents.

(ii) Encouraging or directing individuals to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of subsection (2)(a) of this section shall not apply with respect to information provided by an individual carrier or agent to an individual regarding the established geographic service area or a restricted network provision of an individual carrier.

(3) (a) Except as provided in subsection (2)(b) of this section, no individual carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be carried because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of paragraph (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the individual.

(4) An individual carrier shall provide reasonable compensation, as provided under the plan of operation of the individual high risk reinsurance pool, to an agent, if any, for the sale of an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(5) No individual carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation or geographic location of the individuals placed by the agent with the individual carrier.

(6) Denial by an individual carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to individuals in this state.

(8) (a) A violation of the provisions of this section by an individual carrier or an agent shall be an unfair trade practice pursuant to the provisions of section 41-1302, Idaho Code.

(b) If an individual carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to individuals in this state, the third party administrator shall be subject to the provisions of this section as if it were an individual carrier.

**41-5214. ENHANCED SHORT-TERM PLANS.**
The director shall adopt reasonable rules to establish specific standards for enhanced short-term plans. The standards shall be in addition to and in accordance with applicable laws of this state, including this chapter. The standards:

(1) Shall include requirements for renewability that are consistent with federal law regarding short-term, limited duration insurance; and

(2) May include, but need not be limited to:

(a) A scope of covered benefits, which may be as broad as the scope of covered benefits required to be included in individual health benefit plans that are not deemed short-term, limited duration insurance under federal law;

(b) Restrictions on premium rate increases when an enhanced short-term plan ceases to be renewable and the individual policyholder reapplies for coverage from the same carrier; and

(c) Conversion of enhanced short-term plans into fully renewable coverage upon a finding by the director that the conversion complies with law and is in the best interests of the public.

**41-5501. DEFINITIONS.**
As used in this chapter:

(1) "Agent" means a producer as defined in section 41-1003(8), Idaho Code.

(2) "Board" means the board of directors of the Idaho individual high risk reinsurance pool established in this chapter and the Idaho small employer health reinsurance program established in section 41-4711, Idaho Code.

(3) "Carrier" means any entity that provides, or is authorized to provide, health insurance in this state. For purposes of this chapter, carrier includes an insurance company, any other entity providing reinsurance including excess or stop loss coverage, a hospital or professional service corporation, a fraternal benefit society, a managed care organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Dependent" means a spouse, a child or any other individual listed as having coverage under the primary policy holder’s or subscriber’s health benefit plan.

(5) "Director" means the director of the department of insurance of the state of Idaho.

**41-5901. SHORT TITLE.**
This chapter shall be known and may be cited as the "Idaho Health Carrier External Review Act."

**41-5902. PURPOSE AND INTENT.**
The purpose of this chapter is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of a final adverse benefit determination, as defined in this chapter.

**41-5903. DEFINITIONS.**
For purposes of this chapter:

(1) "Administrative record" means all nonprivileged documents, records or other health information which was submitted, considered, generated or relied upon by the health carrier in the course of making the adverse benefit determination, including, but not limited to, documents, records or other information that constitutes the plan's policy statements or guidance concerning the denied treatment or benefit, all records provided by the covered person or the covered person's medical care provider related to the denied treatment or benefit, all records provided to an independent review organization as part of the independent review of the denied treatment or benefit and the opinion issued by the independent review organization.

(2) "Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, and the requested service or payment for the service is therefore terminated, denied or reduced.

(3) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(4) "Authorized representative" means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person’s treating health care professional only when the covered person is unable to provide consent.

(5) "Best evidence" means evidence based on randomized clinical trials.

(a) If randomized clinical trials are not available, then cohort studies or case-control studies;

(b) If studies in paragraph (a) of this subsection (5) are not available, then case-series.

(6) "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

(7) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(8) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(10) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(11) "Cohort study" means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention(s).

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

***41-5903. DEFINITIONS (continued).***

(13) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms and conditions of a health benefit plan.
(14) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.
(15) "Director" means the director of the Idaho department of insurance.
(16) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
(17) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.
(18) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.
(19) "Expedited external review" is the procedure available for urgent care requests for external review.
(20) "Expert" means a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.
(21) "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.
(22) "Final adverse benefit determination" means an adverse benefit determination, as defined in section 41-5903(2), Idaho Code, involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the covered person's health benefit plan.
(23) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
(24) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.
(25) "Health care provider" or "provider" means a health care professional or a facility.
(26) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
(27) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a disability insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.
(28) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:
  (a) The past, present or future physical, mental or behavioral health or condition of an individual or a member of the individual's family;
  (b) The provision of health care services to an individual; or
  (c) Payment for the provision of health care services to an individual.
(29) "Independent review organization" means an entity that conducts independent external reviews of final adverse benefit determinations.
(30) "Investigational" means the definition provided in the covered person's health benefit plan; if the health benefit plan does not provide a definition of "investigational," it shall be defined as follows: Any treatment, procedure, facility, equipment, drug, device or commodity, regardless of its medical necessity, which is experimental, or in the early developmental stage 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 health carrier will be based on objective data and information obtained by the health carrier and reviewed, by competent medical personnel, according to the following:
  (a) The technology has final approval from the appropriate government 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 (c) and (d) of this subsection (30).
(31) "Medically necessary" or "medical necessity" means the definition provided in the covered person's health benefit plan; if the covered person's health benefit plan does not define "medically necessary" or "medical necessity," these terms shall mean health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and 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 covered person's illness, injury or disease;
  (c) Not primarily for the convenience of the covered 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 covered person's illness, injury or disease.
  For these purposes, "generally accepted standards of medical practice" means standards that are based on credible medical or scientific evidence.
(32) "Medical or scientific evidence" means evidence found in the following sources:
  (a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
  (b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd. for indexing in excerpta medicus (EMBASE);
  (c) Medical journals recognized by the U.S. secretary of health and human services under section 1861(t)(2) of the federal social security act;

(d) The following standard reference compendia:
(i) The American hospital formulary service -- drug information;
(ii) Drug facts and comparisons;
(iii) The United States pharmacopoeia -- drug information; and
(iv) The American dental association accepted dental therapeutics.
(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
(i) The federal agency for healthcare research and quality;
(ii) The national institutes of health;
(iii) The national cancer institute;
(iv) The national academy of sciences;
(v) The centers for medicare and medicaid services;
(vi) The federal food and drug administration; and
(vii) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or
(f) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (a) through (e) of this subsection (32).

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(34) "Post service review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(35) "Pre-service review" means utilization review conducted prior to an admission or a course of treatment.

(36) "Protected health information" means health information:
(a) That identifies an individual who is the subject of the information; or
(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(37) "Randomized clinical trial" means a controlled, prospective study of patients who have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(38) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(39) "Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:
(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
(b) In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
(c) The treatment would be significantly less effective if not promptly initiated. The opinion of the covered person's treating health care professional with knowledge of the covered person's medical condition that a request is an urgent care request should be treated with deference.

(40) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, pre-service review, second opinion, certification, concurrent review, case management, discharge planning or post service review.

(41) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

**41-5904. APPLICABILITY AND SCOPE.**

(1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers.

(2) The provisions of this chapter shall not apply to a plan, policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; nor shall this chapter apply to a credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, limited benefit health plans or any other limited supplemental benefit; nor shall this chapter apply to a medicare advantage plan or medicare supplemental policy of insurance, as defined by the director by rule, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55, title 10, of the United States Code and any coverage issued as supplemental to that coverage; nor shall this chapter apply to any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; nor shall this chapter apply to a single employer self-funded employee benefit plan subject to and operated in compliance with the employee retirement income security act of 1974 (ERISA); provided however, the single employer self-funded ERISA employee benefit plan administrator or designee may, by timely and appropriate written notice to the director, voluntarily elect to comply with the provisions of this chapter either for a single plan beneficiary or for a specific period of time. The director may promulgate rules establishing the procedure for an employee benefit plan administrator or designee, to voluntarily comply with the provisions of this chapter and to provide for an administrative fee to be paid by the employee benefit plan administrator for each voluntary external review request submitted to the department pursuant to this chapter.

(3) The availability or use of external review pursuant to this chapter shall not alter the standard of review used by a court of competent jurisdiction when adjudicating the health carrier's final adverse benefit determination.

**41-5905. NOTICE OF RIGHT TO EXTERNAL REVIEW.**

(1) When a final adverse benefit determination is made, the health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, and include the appropriate statements and information set forth in subsection (2) of this section at the same time the health carrier sends written notice of the final adverse benefit determination.

**41-5905. NOTICE OF RIGHT TO EXTERNAL REVIEW (continued).**

(2) The director may prescribe by rule the form and content of the notice required under this section, which shall include:

(a) The following, or substantially equivalent, language:

"We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or your health care service or supply was denied based upon a determination that it was investigational. You may request an external review by submitting a written request to the department of insurance." The notice shall include contact information for the department of insurance, including the website, address and telephone number.

(b) If the adverse benefit determination is for a pre-service or concurrent service, the health carrier shall notify the covered person of the right to an expedited external review if the request is an urgent care request. The notification shall include the definition of urgent care request.

(c) The health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 41-5916, Idaho Code, highlighting the provisions in the external review procedures that give the covered person the opportunity to submit additional information, and include any forms used to process an external review.

(d) The health carrier shall include an authorization form, or other document approved by the director, that complies with the requirements of 45 CFR section 164.508, by which the covered person, for purposes of conducting an external review pursuant to this chapter, authorizes the health carrier and the covered person's treating health care providers to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review. Until the director receives this form from the covered person, duly executed, the external review process is stayed and the health carrier has no obligations under this chapter.

**41-5906. REQUEST FOR EXTERNAL REVIEW.**

A covered person may make a request for an external review of a final adverse benefit determination. Except for a request for an expedited external review as set forth in section 41-5909, Idaho Code, all requests for external review shall be made in writing to the director. The director may prescribe by rule the form and content of external review requests required to be submitted under this section.

**41-5907. EXHAUSTION OF INTERNAL GRIEVANCE PROCESS.**

(1) Except as provided in subsection (2) of this section, a request for an external review pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, shall not be made until the covered person has exhausted the health carrier's internal grievance process. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person:

(a) Has filed and completed a grievance, involving an adverse benefit determination, according to the terms and conditions of the covered person's health benefit plan; or

(b) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty-five (35) days following the date the covered person filed the grievance with the health carrier, or the covered person filed a grievance on an urgent care request on a pre-service or concurrent care adverse benefit determination and has not received a determination from the health carrier within three (3) business days after filing.

(2) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in the health carrier's grievance appeal process whenever:

(a) The health carrier agrees to waive the exhaustion requirement;

(b) The health carrier has failed to strictly follow its duties in affording a timely, full and fair opportunity for the covered person to take advantage of the internal grievance procedures; or

(c) The urgent care request involves a medical condition for which the time frame for completion of the carrier's internal grievance process pursuant to this section would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person has applied for expedited external review at the same time as applying for an expedited internal review.

**41-5908. STANDARD EXTERNAL REVIEW.**

(1) Within four (4) months after the date of issuance of a notice of a final adverse benefit determination pursuant to section 41-5905, Idaho Code, a covered person may file a request for an external review with the director. The request shall be made on such form as may be designated by the director.

(2) Within seven (7) days after the date of receipt of a request for external review pursuant to subsection (1) of this section, the director shall send a copy of the request to the health carrier.

(3) Within fourteen (14) days following the date of receipt of the copy of the external review request from the director pursuant to subsection (2) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a post service review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) The health care service that is the subject of the final adverse benefit determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or the service or supply is investigational;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the covered person's health benefit plan, unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 41-5907, Idaho Code; and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under section 41-5905(2)(d), Idaho Code.

(4) Within five (5) business days after completion of the preliminary review, the health carrier shall notify the director and covered person in writing whether the request is complete and whether the request is eligible for external review.

(5) If the request is not complete, the health carrier shall inform the covered person and the director in writing and include in the notice what information or materials are needed to make the request complete.

(6) If the request is not eligible for external review, the health carrier shall inform the covered person and the director in writing and include in the notice the reasons for its ineligibility.

**41-5908. STANDARD EXTERNAL REVIEW .**

(7) The director may prescribe by rule the form for the health carrier's notice of initial determination under this section and any supporting information to be included in the notice. The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that the external review request is ineligible for review, may be appealed to the director.
(8) The director may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review. The director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.
(9) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, within seven (7) days after the date of receipt of the notice, the director shall:
  (a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 41-5911, Idaho Code, to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and
  (b) Notify, in writing, the covered person of the request's eligibility and acceptance for external review.
  (c) The director shall include in the notice provided to the covered person a statement that the covered person may submit, in writing, to the assigned independent review organization within seven (7) days following the date of receipt of the notice provided pursuant to subsection (9)(b) of this section, additional information that the independent review organization shall consider when conducting the external review.
(10) In reaching a decision, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.
(11) Within fourteen (14) days after the date of receipt of the notice provided pursuant to subsection (9)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.
(12) Except as provided in subsection (13) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subsection (11) of this section, shall not delay the conduct of the external review.
(13) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subsection (11) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination.
(14) Within one (1) business day after making the decision to terminate the external review pursuant to subsection (13) of this section, the independent review organization shall notify the covered person, the health carrier and the director.
(15) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) of this section, and any other information submitted in writing to the independent review organization by the covered person pursuant to subsection (9)(c) of this section; provided however, that if the covered person does submit new information in writing to the independent review organization pursuant to subsection (9)(c) of this section, then the health carrier is entitled to seven (7) days following its receipt thereof to submit additional responsive information to the internal review organization.
(16) Upon receipt of any information submitted by the covered person pursuant to subsection (9)(c) of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.
(17) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (16) of this section, the health carrier may reconsider its adverse determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The assigned independent review organization shall review all of the information and documents received pursuant to subsection (15) of this section.
(18) The external review may be terminated if the health carrier decides to reverse its final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the final adverse benefit determination. Within two (2) business days after making the decision to reverse its final adverse benefit determination, the health carrier shall notify the covered person, the assigned independent review organization and the director in writing of its decision.
(19) In addition to the documents and information provided pursuant to subsection (11) of this section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:
  (a) The covered person's medical records;
  (b) The attending health care professional's recommendation;
  (c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;
  (d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;
  (e) The most appropriate practice guidelines, which shall include the applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, health carrier's internal guidelines and medical policies;
  (f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;
  (g) Medical or scientific evidence, as defined in section 41-5903(32), Idaho Code;
  (h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (19) to the extent the information or documents are available.
(20) Within forty-two (42) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the final adverse benefit determination to the covered person, the health carrier and the director. The independent review organization shall include in the notice:
  (a) A general description of the reason for the request for external review;
  (b) The date the independent review organization received the assignment from the director to conduct the external review;
  (c) The date the external review was conducted;
  (d) The date of its decision;
  (e) The principal reason or reasons for its decision, including an explanation of the scientific or clinical judgment applied to reach its decision;
  (f) References to the evidence or documentation, including the evidence- based standards, considered in reaching its decision; and
  (g) References to the terms and conditions of the health benefit plan at issue, including an explanation of how its decision is consistent with them.

(21) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to section 41-5912, Idaho Code.
(22) Upon receipt of a notice of a decision pursuant to subsection (20) of this section reversing the adverse benefit determination or final adverse benefit determination, the health carrier shall approve as soon as reasonably practicable but not later than one (1) business day after receipt of the notice the coverage that was the subject of the adverse benefit determination or final adverse benefit determination.

**41-5910. BINDING NATURE OF EXTERNAL REVIEW DECISION.**
(1) For a health care benefit plan not subject to the employee retirement income security act of 1974 (ERISA), the external review decision is final and binding on the health carrier and on the covered person. No judicial action or proceeding arising out of the external review decision or the issues determined by the external review decision shall be permitted. For a health care benefit plan subject to ERISA, the external review decision is final and binding on the health carrier; however, should the covered person seek judicial review of the external review decision, then the external review record and decision shall be included as a part of the administrative record for the purpose of review by any court of competent jurisdiction.
(2) A covered person may not file a subsequent request for external review involving the same adverse benefit determination or final adverse benefit determination for which the covered person has already received an external review decision pursuant to this chapter.

**41-5911. APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS.**
(1) The director shall approve independent review organizations eligible to be assigned on a random basis to conduct external reviews under this chapter.
(2) In order to be eligible for approval by the director under this section to conduct external reviews under this chapter an independent review organization shall:
  (a) Except as otherwise provided in this section, be accredited by a nationally recognized private accrediting entity that the director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 41-5912, Idaho Code; and
  (b) Submit an application for approval in accordance with subsection (4) of this section.
(3) The director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.
(4) Any independent review organization wishing to be approved to conduct external reviews under this chapter shall submit the application form and include with the form all documentation and information necessary for the director to determine whether the independent review organization satisfies the minimum qualifications established under section 41-5912, Idaho Code.
(5) The director shall publish prominently on the department of insurance website notice of a submitted application or reapplication by an independent review organization to provide external reviews under this chapter.
  (a) Any person wishing to comment on an application shall have fortytwo (42) days, from the publication of notice by the director, to provide written comments to the director on the application or reapplication submitted by an independent review organization.
  (b) The director shall review and consider the written comments received in determining whether to approve the application or reapplication of an independent review organization.
  (c) The director may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

**41-5912. MINIMUM QUALIFICATIONS FOR INDEPENDENT REVIEW ORGANIZATIONS.**
(1) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:
  (a) A quality assurance mechanism in place that:
    (i) Ensures that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;
    (ii) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;
    (iii) Ensures the confidentiality of medical and treatment records and clinical review criteria; and
    (iv) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;
  (b) A toll free telephone service to receive information on a twentyfour (24) hour day, seven (7) day a week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and
  (c) An agreement to maintain and provide to the director the information set out in section 41-5914, Idaho Code.
(2) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:
  (a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;
  (b) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;
  (c) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and
  (d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

***41-5912. MINIMUM QUALIFICATIONS FOR INDEPENDENT REVIEW ORGANIZATIONS (continued).***

(3) In addition to the requirements set forth in subsection (1) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.
(4) In addition to any other requirements, to be approved to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review, nor any clinical reviewer assigned by the independent organization to conduct the external review, may have a material professional, familial or financial conflict of interest with any of the following:
  (a) The health carrier that is the subject of the external review;
  (b) The covered person whose treatment is the subject of the external review;
  (c) Any officer, director or management employee of the health carrier that is the subject of the external review;
  (d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
  (e) The facility at which the recommended health care service or treatment would be provided; or
  (f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.
(5) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection (4) of this section, the director shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case, or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case, may have an apparent professional, familial or financial relationship or connection with a person described in subsection
(4) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.
(6) An independent review organization that is accredited by a nationally recognized private accrediting entity, which has independent review accreditation standards that the director has determined are equivalent to or exceed the minimum qualifications of this section, shall be presumed in compliance with this section to be eligible for approval under section 41-5911, Idaho Code.
(7) The director shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section.
(8) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the director in order for the director to determine whether the entity's standards are equivalent to or exceed the minimum qualifications established under this section.
(9) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.
(10) Each independent review organization applying to the director to be approved shall include in its application its schedule of costs and fees for performing external reviews and shall file with the director any subsequent changes to its fee schedule. If the director finds that the proposed fees are excessive or unreasonable, the director shall disapprove the application or, if the review organization has already been approved, remove the organization from the list of eligible review organizations. An independent review organization may not impose charges for a review under this chapter that exceed those set forth on its schedule of fees filed with the director.

**41-5913. HOLD HARMLESS FOR INDEPENDENT REVIEW ORGANIZATIONS.**
No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence; provided that the health carrier shall not be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed by the independent review organization, its employees, agents or contractors within the scope of the organization's or person's duties under the law during or upon completion of an external review
conducted pursuant to this chapter.

**41-5914. EXTERNAL REVIEW REPORTING REQUIREMENTS.**
(1) An independent review organization assigned pursuant to this chapter to conduct an external review shall maintain written records in the aggregate for Idaho by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the director, as required under this section. Each independent review organization required to maintain written records on all requests for external review pursuant to this section for which it was assigned to conduct an external review shall submit to the director, upon request or at specified intervals, a report in the format specified by the director.
(2) The report shall include in the aggregate for Idaho for each health carrier:
  (a) The total number of requests for external review;
  (b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the final adverse benefit determinations and the number resolved reversing the final adverse benefit determinations;
  (c) The average length of time for resolution;

  (d) A summary of the types of coverages or cases for which an external review was sought;
  (e) The number of external reviews pursuant to section 41-5908(18), Idaho Code, that were terminated as the result of a reconsideration by the health carrier of its final adverse benefit determination after the receipt of additional information from the covered person; and
  (f) Any other information the director may reasonably request or require.
(3) The independent review organization shall retain the written records required pursuant to this section for at least five (5) years.
(4) Each health carrier shall maintain written records in the aggregate for Idaho for each type of health benefit plan offered by the health carrier

**41-5915. FUNDING OF EXTERNAL REVIEW.**
The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the reasonable cost of the independent review organization for conducting the external review.

**41-5916. DISCLOSURE REQUIREMENTS.**
(1) Each health carrier shall include a summary description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. The disclosure shall be in a format prescribed by the director.
(2) The description required under subsection (1) of this section shall include:
(a) A statement that informs the covered person of the right of the covered person to file a request for an external review of a final adverse benefit determination with the director;
(b) An explanation that external review and, in certain circumstances, expedited external review are available when the final adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or investigational service or supply;
(c) The website, telephone number and address of the director; and
(d) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review including any judicial review of the external review decision pursuant to ERISA, if applicable.
(e) If the health plan is not subject to ERISA, a statement informing the covered person that the plan is not subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on both the covered person and the health carrier, as provided in section 41-5910, Idaho Code. If the health plan is subject to ERISA, the statement shall inform the covered person that the plan is subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on the health carrier but not the covered person, as provided in section 41-5910, Idaho Code, and that the covered person may have the right to judicial review under ERISA in a court of competent jurisdiction.

**41-5917. SEVERABILITY.**
The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

**Reference: Bulletin 18.01.05**

**DATE:** June 13, 2011
**TO:** Disability/Health Insurance Carriers, Independent Review Organizations and Single Employer Self-funded Plan Administrators
**FROM:** William W. Deal, Director
**SUBJECT:** Idaho Health Carrier External Review Act Amendments

The purpose of this bulletin is to alert health insurance carriers, independent review organizations, and administrators for single employer self-funded ERISA employee benefit plans to important changes to the Idaho Health Carrier External Review Act (Title 41, Chapter 59 of the Idaho Code). House Bills 131 and 299 amended the following sections of the act for health benefit plans in Idaho effective July 1, 2011:

1. **Section 41-5903(2):** The definition of "adverse benefit determination" was revised to include denials based on **"appropriateness, health care setting, level of care, effectiveness,"** in addition to denials based on medical necessity and investigational services.
2. **Section 41-5903(39):** The definition of "urgent care request" was revised to include **"a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility,"** in addition to the existing language in that definition.
3. **Section 41-5904:** Subsection (1) was revised to remove unnecessary language. The revisions to subsection (2) provide that an administrator or designee of a single employer self-funded ERISA employee benefit plan may voluntarily elect to comply with Idaho's external review act. The administrator or designee must give timely and appropriate written notice to the director. The election may be for a single plan beneficiary or for a specific period of time.
4. **Section 41-5905:** Language in this section was updated to be consistent with the inclusion of additional reasons for denial in the definition of an adverse benefit determination referenced above.
5. **Sections 41-5906 and 41-5915:** The sections were changed to delete the director's authority to establish by rule a filing fee to be paid by the covered person for an external review request filed with the department.
6. **Section 41-5907:** The requirements for what constitutes exhaustion of the health carrier's internal grievance process now include:
   - When a carrier fails to give a timely, full and fair opportunity for the covered person to take advantage of the carrier's internal grievance process.
   - A covered person may file for an internal grievance with the carrier and an expedited external review with the department at the same time for an urgent care request involving a medical condition where any delay would jeopardize the person's life, health, or the ability to regain maximum function.
7. **Section 41-5908(22):** When a health carrier receives notice from an independent review organization reversing an adverse benefit determination for a standard external review request, the carrier must approve coverage as soon as practicable but not later than one business day after receipt of notice.
8. **Section 41-5909:** For expedited external review requests:
   - In subsection (1 ), a covered person may request an expedited review at exhaustion of the health carrier's internal grievance process or at the same time as filing an internal appeal as provided in Section 41-5907.
   - In subsection (11 ), when a health carrier receives notice from an independent review organization reversing an adverse benefit determination, the carrier must notify the director and covered person of its intent to pay the covered benefit as soon as practicable but not later than one business day after receipt of notice.

The department will revise its Health Carrier External Review rule, IDAPA 18.01 .05, to comply with the amended act. Health carriers must file revised forms with the department's Rates and Forms section. Attached are language changes required for these notices (Note: the language changes include strike-through and are underlined for your information only. The filed forms do not need to include strike-through or underlining.):

- Appendix A, "Your Right to an Independent External Review" as required by Section 41-5916; and
- Appendix B, "Notice of Your Right to an Independent External Review" as required by Section 41-5905.

As part of the revisions to IDAPA 18.01.05, the department will delete the annual reporting requirements for health carriers and independent review organizations in Section 024 of that rule. Section 024 will be replaced with the requirements for "Voluntary Election by ERISA Plan Administrator," explaining the written notice requirements for plan administrators or designees.
The department will revise the external review request forms and other information posted on its website for these changes effective July 1, 2011. Any questions regarding this bulletin may be directed to Eileen Mundorff, Consumer Affairs Officer, 208-334- 4326 or by email to: eileen.mundorff@doi.idaho.gov

## Appendix A

The summary description below provides an acceptable format approved by the director as meeting the requirements of Section 41-5916, Idaho Code. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

### YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

**Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.**

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. <u>You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if any delay would seriously jeopardize your life, health or ability to regain maximum function.</u>

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's web site, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

**Standard External Review Request:** You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

**Expedited External Review Request:** You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time .

. **"Urgent care request"** means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. 2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. 3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of ~~the approval of coverage~~ our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after ~~making the determination~~ receiving notice of the decision.

**Binding Nature of the External Review Decision:** If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

## Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

### NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

**Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final. Except in limited circumstances, you will have no further right to have your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity.**

We have denied your request to provide or pay for a health care service or supply. You may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or
Our determination your health care service or supply was investigational.

**No later than four months from the date of this denial,** you may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3**rd** Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's web site, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require for review to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our decision will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

**Standard External Review Request:** You must file your written external review request with the department **within four months** after the date we issued this notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

**Expedited External Review Request:** You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

**"Urgent care request"** means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of the approval of coverage our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after making the determination receiving notice of the decision.

**Binding Nature of the External Review Decision:** [NOTE TO HEALTH CARRIERS: The carrier must include one of the applicable paragraphs below for the covered person's health benefit plan.}

[Your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the independent review organization will be final and binding on the health insurer, but you may have additional review rights provided under federal ERISA laws.}

[The external review decision by the independent review organization will be final and binding on both you and us. **This means that** if **you elect to request external review of your claim, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of your claim after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.]

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

**Reference: Bulletin 03-08 was replaced by Bulletin 18-06.**
**Reference: Bulletin 18-06**

# BULLETIN N0. 18-06

**DATE**: July 13, 2018

**TO:** Property and Casualty Insurers and Insurance Producers Writing Property and Casualty Business in Idaho

**FROM:** Dean L. Cameron, Director

**SUBJECT:** Certificates of Insurance

## Background and Introduction

In 2012, Idaho Code § 41-1850, concerning the filing and use of certificates of insurance was added by SB 1390, which also amended Idaho Code § 41-1823, applicable to binders. In 2018, HB 522 amended Idaho Code § 41-1850 to allow certificates of insurance to include a reference to a contract or project number or description. This bulletin modifies and updates Bulletin 12-08 by highlighting certain provisions of Idaho Code § 41-1850 and supersedes Bulletin Nos. 12-03, 08-03 and 68-1 on the same subject.

## Certificates of Insurance

Idaho Code § 41-1850(2) prohibits any person from preparing, issuing or knowingly requesting the issuance of a certificate of insurance unless the form of the certificate has been filed with the Director of the Department of Insurance (Director) by or on behalf of an insurer. The Director has received and accepted filings of certificate of insurance forms filed by ISO and certain carriers. Consistent with Idaho Code § 41-1850(5), if a carrier uses a filed ISO or ACORD form, that form need not be refiled by each carrier. Additionally, where other law provides for a particular certificate of insurance form to be used, once that form has been filed by or on behalf of an insurer with the Director, then individual carriers will not need to refile the form.

Pursuant to Idaho Code § 41-1850(3) the Director may disapprove any form filed with the Director if the Director finds that it (i) is unfair, misleading or deceptive or violates public policy; (ii) fails to comply with the requirements of Idaho Code § 41-1850; or (iii) violates any other provisions of title 41, Idaho Code, or any rule promulgated by the Director. Furthermore, although Idaho Code § 41-1850(3) references the Director's authority to withdraw approval of a form, Idaho is generally a certify, file and use state other than for specific provisions, where the Director does not expressly approve filed forms. Carriers filing certificate of insurance forms will be required to certify that the form complies with Idaho law. The Director has the authority, however, to disapprove at any time any filed form that does not comply with the requirements of Idaho Code § 411850(3).

Idaho Code § 41-1850(4) codifies elements of Bulletin Nos. 68-1 and 08-3* by requiring that each certificate of insurance include the following or a similar statement:

> This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend coverage, terms, exclusions and conditions afforded by the policies referenced herein

Idaho Code § 41-1850(6) and (7) prohibit any person from knowingly demanding or requesting or knowingly preparing or issuing a certificate of insurance or other document, record or correspondence that contains false or misleading information or purports to affirmatively or negatively alter, amend or extend coverage provided by the policy of insurance to which a certificate of insurance makes reference. Idaho Code § 41-1850(10), amended in 2018, still confirms that the insurance referenced in a certificate is subject to all terms, exclusions and conditions of the policy itself. However, the amendment allows a certificate of insurance to include reference to a contract number or description or a project number or description, but by doing so the certificate may not and does not warrant that the referenced policy complies with the insurance or indemnification requirements of a contract or project.

The Director is authorized to impose an administrative penalty up to $1,000 per individual and up to $5,000 per entity, pursuant to Idaho Code § 41-117 for any violation of Idaho Code § 41-1850. The new legislation does not alter the authority of the Director to investigate and seek redress for violations of other provisions of the Idaho Code where such violations are associated with the issuance of a certificate of insurance, including without limitation, Idaho Code § 41-1016(1)(e) (illegal for a producer to misrepresent the terms of an insurance contract), § 41-1303 (illegal for any person to make a statement misrepresenting the terms of an insurance policy); and § 41-293(1)(c) (insurance fraud, a felony, includes presenting to a person, with intent to defraud or deceive, a false statement material to an insurance contract).

Any questions concerning certificates of insurance or filing procedures should be directed to the Rates and Forms Section of the Department.

*Bulletins 68-1 and 08-3, which are superseded by this bulletin, required the following language in each certificate: "This Certificate of Insurance neither affirmatively nor negatively amends, extends, nor alters the coverage afforded by the policy or policies numbered in this certificate." The Department considers this language sufficiently similar to the new statutory language to be permissible.

# 18.01.01 – RULE TO IMPLEMENT THE PRIVACY OF CONSUMER FINANCIAL INFORMATION

000.LEGAL AUTHORITY.
Title 41, Chapter 13, Section 41-1334, Idaho Code.

**001.TITLE AND SCOPE.**

01. Title. IDAPA 18.01.01, "Rule to Implement the Privacy of Consumer Financial Information."
02. Scope. This rule describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties and provides methods for individuals to prevent a licensee from disclosing that information.
03. Applicability. This rule applies to nonpublic personal financial information about individuals who obtain or are beneficiaries of products or services primarily for personal, family, or household purposes from licensees. This rule does not apply to information about companies or individuals who obtain products or services for business, commercial, or agricultural purposes.

**002. -- 009.(RESERVED)**

**010.DEFINITIONS.**
All terms defined in Title 41, Chapters 1 and 13, Idaho Code, that are used in this rule have the same meaning as used in those chapters. In addition, the following terms are defined as used in this chapter.

01. Clear and Conspicuous.
    a. A notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice if it:
        i. Presents the information in clear, concise sentences, paragraphs, and sections;
        ii. Uses short explanatory sentences or bullet lists whenever possible;
        iii. Uses definite, concrete, everyday words and active voice whenever possible;
        iv. Avoids multiple negatives;
        v. Avoids legal and highly technical business terminology whenever possible;
        vi. Avoids explanations that are imprecise and readily subject to different interpretations.
        vii. Uses an easy-to-read typeface and type size, and uses boldface or italics for key words; and
        viii. When in a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices.
    b. If a licensee provides a notice on a web page, the notice needs to call attention to the nature and significance of the information in the notice and place the notice on a screen that consumers frequently access, or place a link on a screen that consumers frequently access that connects directly to the notice.
02. Collect. To obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifiers assigned to the individual.
03. Company. A corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.
04. Consumer. An individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee used primarily for personal, family, or household purposes. Examples:
    a. An individual who provides nonpublic personal information to a licensee in connection with an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.
    b. An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for or provides processing or other services to the financial institution.
    c. If the licensee provides the initial, annual, and revised notices under Sections 100, 150, and 300 of this rule to the plan sponsor, group or blanket insurance policyholder, or group annuity contract holder, and if the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about an individual other than as permitted under Sections 450, 451, and 452 of this rule, an individual is not the consumer of the licensee solely because he is:
        i. A participant or a beneficiary of an employee benefit plan the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary; or
        ii. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee.
        iii. A beneficiary in a workers' compensation plan.
    d. An individual is not a licensee's consumer solely because he is:
        i. A beneficiary of a trust for which the licensee is a trustee; or
        ii. Designated the licensee as trustee for a trust.
05. Consumer Reporting Agency. Is the same meaning as found in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).
06. Control:
    a. Ownership, control, or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one (1) or more other persons;
    b. Control in any manner over the election of a majority of the directors, trustees, or general partners (or individuals exercising similar functions) of the company; or
    c. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines.
07. Customer. A consumer who has a customer relationship with a licensee.
08. Customer Relationship. A continuing relationship between a consumer and a licensee under which the licensee provides one (1) or more insurance products or services to the consumer to be used primarily for personal, family, or household purposes.
    a. A consumer does not have a continuing relationship with a licensee if:
        i. The licensee sells the consumer travel insurance in an isolated transaction;
        ii. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;
        iii. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing either a lump sum settlement option or a settlement option involving an ongoing relationship with the licensee;
        iv. The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

09. Financial Institution. Any institution engaging in activities that are financial in nature. Financial institution does not include:
    a. Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);
    b. The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or
    c. Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.
10. Financial Product or Service. A product or service that a financial holding company could offer including a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.
11. Licensee.
    a. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in this rule if the licensee is an employee, agent, or other representative of another licensee ("the principal") and:
        i. The principal complies with, and provides the notices prescribed by this rule; and
        ii. The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this rule.
    b. A licensee also includes an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Title 41, Chapter 12, Idaho Code.
12. Nonpublic Personal Information.
    a. Means personally identifiable financial information; including any list, description or other grouping of consumers (see archived 18.01.48) derived using any personally identifiable financial information not publicly available.
    b. Nonpublic personal financial information does not include:
        i. Health information;
        ii. Publicly available information, except as included on a list described in Subparagraph 010.11.a., of this rule; or
        iii. Any list, description or other grouping of consumers derived without using any personally identifiable financial information that is not publicly available.
13. Opt Out. A direction by the consumer that the licensee not disclose nonpublic personal financial information about the consumer to a nonaffiliated third party.
14. Personally Identifiable Financial Information.
    a. Any information:
        i. A consumer provides to a licensee to obtain an insurance product or service from the licensee;
        ii. About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer.
    b. Examples of personally identifiable financial information:
        i. Account balance information and payment history;
        ii. The fact that an individual is or has been one (1) of the licensee's customers or has obtained an insurance product or service from the licensee;
        iii. Information about the licensee's consumer if it is disclosed in a manner that indicates the individual is or has been the licensee's consumer;
        iv. Information provided by a consumer to a licensee or that the licensee or its agent obtains in connection with collecting on a loan or servicing a loan;
        v. Information the licensee collects through an Internet cookie (an information-collecting device from a web server); and
        vi. Information from a consumer report.
    c. Personally identifiable financial information does not include:
        i. Health information;
        ii. A list of names and addresses of customers of an entity of a non-financial institution; and
        iii. Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.
15. Publicly Available Information.
    a. Any information that a licensee has a reasonable basis to believe is lawfully made available to the general public.

**011. -- 099. (RESERVED)**

**100. INITIAL PRIVACY NOTICE TO CONSUMERS.**

01. Initial Notice Requirement. A licensee will provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:
    a. A customer no later than when the licensee establishes a customer relationship, except as provided in Subsection 100.03 of this rule; and
    b. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by Sections 451 and 452.
02. Existing Customers. When an existing customer obtains a new insurance product or service from a licensee, which is used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of Subsection 100.01 of this rule if the notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection 100.01 of this rule.
03. Exceptions Allowing Subsequent Delivery of Notice. A licensee may provide the initial notice prescribed in Paragraph 100.01.a. of this rule in a reasonable time after the licensee establishes a customer relationship if:
    a. Establishing the customer relationship is not at the customer's election; or
    b. It would avoid substantially delaying the customer's transaction and the customer agrees to receive the notice at a later time.

**101. -- 149.(RESERVED)**

**150. ANNUAL PRIVACY NOTICE TO CUSTOMERS.**

01. General Rule. A licensee will provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship.
02. Exceptions: Termination of Customer Relationship and Duplicate Notices.
    a. A licensee is not obligated to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a customer relationship.
        i. In the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.
    c. Notwithstanding Subsection 150.01, a licensee is not obligated to provide the annual privacy notice to a current customer if the licensee:
        i. Provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 450, 451, and 452; and
        ii. Has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with Section 100 or Section 150.

**151. -- 199.(RESERVED)**

**200.INFORMATION TO BE INCLUDED IN PRIVACY NOTICES.**

The initial, annual and revised privacy notices a licensee provides, under Sections 100, 150, and 300, needs to include each of the following items of information, in addition to any other information the licensee wishes to provide:

01. Information Licensee Collects or Discloses. The categories of nonpublic personal financial information the licensee collects or discloses.
02. Parties to Whom Licensee Discloses. The categories of third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under Sections 451 and 452.
03. Disclosures of Information About Former Customers. The categories of nonpublic personal financial information about the licensee's former customers the licensee discloses, and the categories of third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under Sections 451 and 452.
04. Disclosures Under Section 450. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 450 (and no other exception in Sections 451 and 452 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted is to provided.
05. Explanation of Right to Opt Out. An explanation of the consumer's right under Subsection 400.01 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise their right at that time.
06. Disclosures Under Federal Law. Any disclosures the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (notices regarding the ability to opt out of disclosures of information among affiliates); and the licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

**201.DESCRIPTION OF PARTIES SUBJECT TO EXCEPTIONS.**

If a licensee discloses nonpublic personal financial information as authorized under Sections 451 and 452, the licensee is not obligated to list those exceptions in the initial or annual privacy notices prescribed by Sections 100 and 150. When describing the categories of parties to whom disclosure is made, the licensee will state only that it makes disclosures to other third parties.

**202.SATISFYING THE PRIVACY NOTICE INFORMATION REQUIREMENTS.**

01. Categories of Nonpublic Personal Financial Information That the Licensee Collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:
    a. Information from the consumer;
    b. Information about the consumer's transactions with the licensee, its affiliates, or third parties;
    c. Information from a consumer reporting agency.
02. Categories of Nonpublic Personal Financial Information a Licensee Discloses.
    a. A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes it according to the source, as described in Subsection 202.01 of this rule, and provides a few examples to illustrate the types of information in each category.
    b. If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information the licensee discloses.
03. Categories of Affiliates and Nonaffiliated Third Parties to Whom the Licensee Discloses. A licensee satisfies the requirement to categorize the third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage. Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business.
04. Disclosures Under Exception for Service Providers and Joint Marketers. If a licensee discloses nonpublic personal financial information under the exception in Section 450 to a nonaffiliated third party to market products or services it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection 200.04 of this rule if it:
    a. Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Subsection 200.01 of this rule; and
    b. States whether the third party is:
        i. A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or
        ii. A financial institution with whom the licensee has a joint marketing agreement.
05. Simplified Notices. If a licensee does not disclose and does not wish to reserve the right to disclose nonpublic personal financial information about customers or former customers to third parties except as authorized under Sections 451 and 452, the licensee may simply state that fact, in addition to the information it provides under Subsections 200.01, 200.07, and Section 201 of this rule.
06. Confidentiality and Security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:
    a. Describes in general terms who is authorized to have access to the information; and
    b. States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy.

**203.SHORT-FORM INITIAL NOTICE WITH OPT OUT NOTICE FOR NON-CUSTOMERS.**

01. Short-Form Initial Notice Allowed. A licensee may satisfy the initial notice requirements for a consumer who is not a customer, by providing a short-form initial notice at the same time the licensee delivers an opt out notice as prescribed in Section 250.
02. Short-Form Initial Notice Requirements. A short-form initial notice will:
    a. Be clear and conspicuous;
    b. State that the licensee's privacy notice is available upon request; and
    c. Explain a reasonable means by which the consumer may obtain the notice.
03. Delivery of Short-Form Initial Notice. The licensee is not obligated to deliver its privacy notice with its short-form initial notice but may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee will deliver its privacy notice according to Section 350.
04. Examples of Obtaining Privacy Notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:
    a. Provides a toll-free telephone number the consumer may call to request the notice;
    b. Maintains copies of the notice on hand at the licensee's office and provides it to the consumer immediately upon request; or
    c. Posts it on their website.

**204. -- 249.(RESERVED)**

**250.FORM OF OPT OUT NOTICE TO CONSUMERS**.

01. Opt Out Notice Form. If a licensee is prescribed to provide an opt out notice under Subsection 400.01, it will provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under Section 400. The notice will state:
    a. The licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
    b. The consumer has the right to opt out of that disclosure; and
    c. A reasonable means by which the consumer may exercise the opt out right.
02. Adequate Opt Out Notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:
    a. Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, and states that the consumer can opt out of the disclosure of that information; and
    b. Identifies the insurance products or services that the consumer obtains from the licensee to which the opt out direction would apply.
03. Reasonable Means to Exercise an Opt Out Right. A licensee provides a reasonable means to exercise an opt out right if it:
    a. Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;
    b. Includes a reply form together with the opt out notice;
    c. Provides an electronic means to opt out, if the consumer agrees to the electronic delivery of information; or
    d. Provides a toll-free telephone number that consumers may call to opt out.

**251.PROVIDING OPT OUT NOTICE TO CONSUMERS AND COMPLYING WITH OPT OUT DIRECTION.**

01. Joint Relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice providing any of the joint consumers to exercise the right to opt out. The licensee may either:
    a. Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or
    b. Permit each joint consumer to opt out separately.
    c. A licensee cannot require all joint consumers to opt out before it implements any opt out direction.
02. Time to Comply with Opt Out. A licensee will comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.
03. Continuing Right to Opt Out. A consumer may exercise the right to opt out at any time.
04. Duration of Consumer's Opt Out Direction.
    a. A consumer's direction to opt out under Sections 250 and 251 is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.
    b. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.
    05. Delivery. When a licensee is prescribed to deliver an opt out notice by Section 250, the licensee will deliver it according to Section 350.

**252. -- 299.(RESERVED)**

**300.REVISED PRIVACY NOTICES.**

01. General Rule. A licensee will not disclose any nonpublic personal financial information other than as described in the initial notice that the licensee provided to that consumer under Section 100, unless:
a. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;
b. The licensee has provided to the consumer a new opt out notice;
c. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and
d. The consumer does not opt out.

**301. -- 349.(RESERVED)**

**350.DELIVERY.**

01. How to Provide Notices. A licensee will make available any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.
02. Reasonable Expectation of Notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:
    a. Hand-delivers a printed copy of the notice to the consumer;
    b. Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication; or
    c. For a consumer who conducts transactions electronically, or an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service.
03. Annual Notices Only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:
    a. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or
    b. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.
04. Oral Description of Notice Insufficient. A licensee cannot provide any notice prescribed by this rule solely by orally explaining the notice.
05. Retention or Accessibility of Notices for Customers.
    a. For customers only, a licensee will provide all notices so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.
    b. Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:
    i. Hand-delivers a printed copy of the notice to the customer;
    ii. Mails a printed copy of the notice to the last known address of the customer; or
    iii. Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.
06. Joint Notice with Other Financial Institutions. A licensee may provide a joint notice from the licensee and one (1) or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

**351. -- 399.(RESERVED)**

**400.LIMITS ON DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION TO NONAFFILIATED THIRD PARTIES.**

01. Conditions for Disclosure.
    a. Except as authorized in this rule, a licensee will not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:
        i. The licensee has provided to the consumer an initial notice as prescribed under Section 100;
        ii. The licensee has provided to the consumer an opt out notice as prescribed in Sections 250 and 251;
        iii. The licensee has given the consumer a reasonable opportunity to opt out of the disclosure before it discloses the information to the nonaffiliated third party; and
        iv. The consumer does not opt out.
    b. If a consumer opts out, the licensee cannot disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 450, 451, and 452.
    c. Examples of a reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if the licensee mails the notices prescribed in Subsection 400.01 of this rule to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means in thirty (30) days from the date of mailing.
02. Application of Opt Out to All Consumers and All Nonpublic Personal Financial Information.
    a. A licensee will comply with Section 400, regardless of whether the licensee and the consumer have established a customer relationship.
    b. Unless a licensee complies with Section 400, the licensee will not disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.
03. Partial Opt Out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

**401.LIMITS ON REDISCLOSURE AND REUSE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.**

01. Information the Licensee Receives Under an Exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution, the licensee may disclose the information only:
    a. To the affiliates of the financial institution from which the licensee received the information; and
    b. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information.
02. Information a Licensee Discloses Under an Exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party, the third party may disclose that information only:
    a. To the licensee's affiliates;
    b. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and
    c. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

**402.LIMITS ON SHARING ACCOUNT NUMBER INFORMATION FOR MARKETING PURPOSES.**

A licensee will not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

**403. -- 449.(RESERVED)**

**450.EXCEPTION TO OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR SERVICE PROVIDERS AND JOINT MARKETING.**

01. General Rule.
    a. The opt out requirements in Sections 250, 251 and 400 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:
        i. Provides the initial notice in accordance with Section 100; and
        ii. Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in Section 451 or 452 in the ordinary course of business to carry out those purposes.

**451.EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR PROCESSING AND SERVICING TRANSACTIONS.**

01. Exceptions. The requirements for initial notice in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:
    a. Servicing or processing an insurance product or service that a consumer requests or authorizes;
    b. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;
    c. A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or
    d. Reinsurance or stop loss or excess loss insurance.

**452.OTHER EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.**

01. Exceptions to Opt Out Requirements. The requirements for initial notice to consumers in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 do not apply when a licensee discloses nonpublic personal financial information:
    a. With the consent or at the direction of the consumer;
    b. To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;
    c. To protect against or prevent actual or potential fraud or unauthorized transactions;
    d. For prescribed institutional risk control or for resolving consumer disputes or inquiries;
    e. To persons holding a legal or beneficial interest relating to the consumer; or
    f. To persons acting in a fiduciary or representative capacity on behalf of the consumer;
    g. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies rating a licensee, persons assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;
    h. To the extent specifically permitted or prescribed under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, and the Federal Trade Commission), with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, self-regulatory organizations or for an investigation on a matter related to public safety;
    i. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or from a consumer report reported by a consumer reporting agency;
    j. In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;
    k. To comply with federal, state or local laws, rules, and other applicable legal requirements; to comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law;
    l. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan; or
    m. With the consent of or at the direction of a liquidator or rehabilitator appointed pursuant to Chapter 33, Title 41, Idaho Code.

**453. -- 499.(RESERVED)**

**500.NONDISCRIMINATION.**

A licensee will not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of their nonpublic personal financial information pursuant to the provisions of this rule.

**501. -- 999.(RESERVED)**

**Attachment to 18.01.01-Rule to Implement the Privacy of Consumer Financial Information**

**Appendix A Sample Clauses**

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

**A-1-Categories of information a licensee collects (all institutions)**

A licensee may use this clause, as applicable, to meet the requirement to describe the categories of nonpublic personal information the licensee collects. Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:
Information we receive from you on applications or other forms;
Information about your transactions with us, our affiliates or others; and
Information we receive from a consumer reporting agency.

**A-2-Categories of information a licensee discloses (institutions that disclose outside of the exceptions)**

A licensee may use one of these clauses, as applicable, to meet the requirement to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in Sections 450, 451, and 452.

**Sample Clause A-2, Alternative 1:**

We may disclose the following kinds of nonpublic personal information about you:
Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and
Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

**Sample Clause A-2, Alternative 2:**

We may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

**A-3-Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)**

A licensee may use this clause, as applicable, to meet the requirements to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in Sections 451 and 452.

**Sample Clause A-3:**

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

**A-4-Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)**

A licensee may use this clause, as applicable, to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 450, 451, and 452, as well as when permitted by the exceptions in Sections 451 and 452.

**Sample Clause A-4:**

We may disclose nonpublic personal information about you to the following types of third parties:
Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];
Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and
Others, such as [provide illustrative examples, such as "non-profit organizations"].
We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law. A-5-Service provider/ joint marketing exception A licensee may use one of these clauses, as applicable, to meet the requirements related to the exception for service providers and joint marketers in Section 450. If a licensee discloses nonpublic personal information under this exception, the licensee describes the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

**Sample Clause A-5, Alternative 1:**

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:
Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and
Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

**Sample Clause A-5, Alternative 2:**

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

**A-6-Explanation of opt out right (institutions that disclose outside of the exceptions)**

A licensee may use this clause, as applicable, to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 450, 451, and 452.

**Sample Clause A-6:**

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)"].

**A-7-Confidentiality and security (all institutions)**

A licensee may use this clause, as applicable, to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

**Sample Clause A-7:**

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal rules to guard your nonpublic personal information.

# IDAHO SPECIFIC CONTENT OUTLINE: ACCIDENT, HEALTH OR SICKNESS

## State Laws, Rules, and Regulations

**Reference: IDAPA 18.01.02**

**IDAPA 18.01.02 – Schedule of Fees, Licenses, and Miscellaneous Charges**

Title 41, Chapters 2 and 4, Idaho Code, Idaho Code.

**001.SCOPE.**
The purpose of this rule is to provide for the amounts to be collected for fees, licenses and miscellaneous charges.

**002. -- 010.(RESERVED)**

**011.FEES PAYABLE IN ADVANCE.**
The director will collect in advance fees, licenses, and miscellaneous charges as outlined in this rule.

**012. -- 019.(RESERVED)**

**020.INSURER FEES.**

01. Annual Continuation Fee. All insurers and other entities (set forth in Section 020) licensed, listed, or approved to do business in the state of Idaho will pay an annual continuation fee.
    a. The annual continuation fee is due on March 1st each year and is payment of the insurer's fees due through the following February.
    b. The annual continuation fee is charged at the time the insurer applies for admission to do business in the state of Idaho. If the application is approved, the fee paid will cover the insurer's fees through the following February.
02. Fee for Insurers. For all insurance companies receiving a certificate of authority pursuant to Title 41, Chapter 3, Idaho Code, the annual continuation fee is as follows:
    a. If insurer's policy holders' surplus at the preceding December 31 is less than ten million dollars ($10,000,000) - One thousand dollars ($1,000).
    b. If insurer's policy holders' surplus at the preceding December 31 is ten million ($10,000,000) or more, but less than one hundred million ($100,000,000) -- Two thousand five hundred dollars ($2,500).
    c. If insurer's policy holders' surplus at the preceding December 31 is one hundred million ($100,000,000) or greater - Four thousand five hundred dollars ($4,500).
03. Fees of Other Entities. The following entities will be assessed an annual continuation fee:
    a. Five hundred dollars ($500):
        i. All reinsurers, listed pursuant to Section 41-515, Idaho Code.
        ii. Authorized surplus line insurers.
        iii. County mutual insurers.
        iv. Fraternal benefit societies.
        v. Hospital and/or professional service corporations.
        vi. Self-funded health care plans.
        vii. Domestic Risk retention groups.
        viii. Petroleum clean water trusts.
        ix. Rating organizations.
        x. Advisory organizations.
    b. One hundred dollars ($100): Purchasing groups.
04. Fees Provide. The annual continuation fee includes, but is not limited to, the following:
    a. Certificate of authority renewal, license renewal, and annual registration.
    b. Arson, fire and fraud investigation costs.
    c. Annual statement filing.
    d. Agent appointment and renewal of appointment.
    e. Filings under Title 41, Chapter 38, Idaho Code, Acquisitions of Control and Insurance Holding Company Systems.
    f. Filing of amendments to Articles of Incorporation.
    g. Filing of amendments to Bylaws.
    h. Amendments to Certificate of Authority.
    i. Filing of notice of significant transactions pursuant to Section 41-345, Idaho Code.
    j. Quarterly statement filing.
    k. Examination expenses.
05. Not Provided in Fees. Payment of the annual continuation fee will not exempt the insurer or entity from the following:
    a. Fees for application for producer license.
    b. Costs incurred by the Department for investigation of an applicant for producer license.
    c. Attorney's fees and costs incurred by the Department when allowed pursuant to Idaho Code.
    d. Costs incurred for experts and consultants when allowed by Idaho Code.
    e. Penalties or fines levied by or payable to the Department of Insurance.
    f. All fees set forth under Section 040.
06. Failure to Pay Fee. Failure to pay the annual continuation fee on or before March 1st each year will result in the expiration of the insurer's or entity's authority to do business in the state of Idaho pursuant to Section 41-324, Idaho Code.
07. Reinstatement Fee. The reinstatement fee referenced in Section 41-324(3), Idaho Code, is the amount referenced above for the insurer or entity continuation fee.

**021. -- 029.(RESERVED)**

**030.PRODUCER AND MISCELLANEOUS LICENSING FEES.**

01. Original License Application. The following fees are due and need to be paid with the filing application for original license:
    a. Administrators -- three hundred dollars ($300).
    b. Producers -- eighty dollars ($80).
    c. Designation as a managing general agent -- eighty dollars ($80).
    d. Adjusters and public adjusters -- eighty dollars ($80).
    e. Reinsurance intermediary -- eighty dollars ($80).
    f. Surplus line brokers -- eighty dollars ($80).
    g. Life settlement providers -- five hundred dollars ($500).
    h. Life settlement brokers -- three hundred dollars ($300).
    i. Independent review organization -- five hundred dollars ($500).
    j. Vendor of portable electronics insurance, a type of limited lines producer:
        i. A vendor of portable electronic insurance who is engaged in portable electronic transactions at more than ten (10) locations in the state of Idaho -- one thousand dollars ($1,000).
        ii. A vendor of portable electronic insurance who is engaged in portable electronic transactions at ten (10) or fewer locations in the state of Idaho -- one hundred dollars ($100).
02. Examination Fees. Each time a producer or adjuster's examination is taken for licensing under Title 41, Chapters 10 and 11, Idaho Code, the applicant may pay a fee to a third-party testing vendor in the amount established by contract between the department and the vendor.
03. Fingerprint Processing. Processing fingerprints (as applicable) -- not to exceed eighty dollars ($80).
04. License Renewal. The following fees are due and need to be paid for each license to renew or continue:
    a. Adjusters, public adjusters, and producers (biennial) -- eighty dollars ($80), or sixty dollars ($60) if renewed electronically.
        i. A vendor of portable electronic insurance who is engaged in portable electronic transactions at more than ten (10) locations in the state of Idaho -- five hundred dollars ($500).
        ii. A vendor of portable electronic insurance who is engaged in portable electronic transactions at ten (10) or fewer locations in the state of Idaho -- one hundred dollars ($100).
    b. Redesignation as managing general agent (annual) -- eighty dollars ($80).
    c. Administrators (biennial) -- eighty dollars ($80).
    i. Renewal form is filed on or before December 31.
        ii. Any renewal form postmarked after December 31 includes a penalty in an amount equal to the renewal fee.
        iii. A renewal form postmarked after January 31 needs to be submitted as a new application with supporting documents and the full application fee.
    d. Surplus line brokers (biennial) -- eighty dollars ($80), or sixty dollars ($60) if renewed electronically.
    e. Life settlement providers (biennial) -- three hundred dollars ($300).
    f. Life settlement brokers (biennial) -- eighty dollars ($80).
    g. Independent review organization (biennial) -- three hundred dollars ($300).

**031. -- 039.(RESERVED)**

**040.MISCELLANEOUS FEES.**

01. Certified Copy. Certified copy of certificate of authority, license or registration - Fifty dollars ($50).
02. Certificate Under Seal. Director’s certificate under seal (except for those under Subsection 040.01 of this rule) - Twenty dollars ($20).
03. Documents Filed. For each copy of a document filed in the DOI, a reasonable cost as fixed by the director. For rate and form filings not submitted electronically through the national System for Electronic Rate and Form Filing (SERFF) -- Twenty dollars ($20) for each rate or form filed in excess of ten (10) per calendar year.
04. Insurer Service of Process. For receiving and forwarding copy of summons or other process served upon the director as process agent of an insurer -- Thirty dollars ($30).
05. Agent Service of Process**.** For receiving and forwarding copy of summons or other process served upon the director as process agent of a nonresident producer or other person for which the director is authorized to serve as statutory agent for service of process -- Thirty dollars ($30).
06. Continuing Education. Filing continuing education applications for approval and certification of subjects of courses (each application) -- Twenty-five dollars ($25).

**041. -- 049.(RESERVED)**

**050.REFUNDS.**

All fees, licenses, and miscellaneous charges are non-refundable except as noted.

**051.OVERPAYMENTS.**

Overpayments of published fees will be returned only when such overpayments exceed twenty dollars ($20), or upon request of the payor.

**052. -- 999.(RESERVED)**

**Reference: IDAPA 18.01.05 doesn't exist see IDAPA '18.01 (all)'**
**Reference: IDAPA 18.04.03**

# IDAPA 18.04.03 – Advertisement of Disability (Accident And Sickness) Insurance

## 000.LEGAL AUTHORITY.

Title 41, Chapters 2 and 13, Idaho Code.

## 001.TITLE AND SCOPE.

01. Title. IDAPA 18.04.03, "Advertisement of Disability (Accident and Sickness) Insurance."
02. Scope. To protect consumers by assuring truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance, including Medicare supplement accident and sickness insurance and long-term care insurance. This is accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability (accident and sickness) insurance in a manner that prevents unfair competition among insurers and promotes an accurate presentation and description to the insurance buying public.

## 002.APPLICABILITY.

01. Disability and Medicare Supplement Insurance. Any disability (accident and sickness) insurance "advertisement," including Medicare supplement and long-term care insurance "advertisement," as that term is defined, intended for presentation, distribution or dissemination in this state when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer.
02. Control over Advertisement. Every insurer will establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements created, designed or presented, are the responsibility of the insurer whose policies are so advertised.

## 003. -- 009.(RESERVED)

## 010.DEFINITIONS.

01. Advertisement. Includes:
    a. Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other internet displays or communications, other forms of electronic communications, billboards and similar displays;
    b. Descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the insurance buying public; and
    c. Prepared sales talks, presentations and material for use by producers whether prepared by the insurer or the producer.
02. Policy. Any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. The term includes contracts for Medicare supplement insurance and long-term care insurance.
03. Insurer. Includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity defined as an "insurer" in the Insurance Code of this state and is engaged in the advertisement of a policy as "policy" is herein defined.
04. Exception. Any provision in a policy where coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.
05. Reduction. Any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be payable had such reduction not been used.
06. Limitation. Any provision that restricts coverage under the policy other than an exception or a reduction.

## 011.METHOD OF DISCLOSURE OF REQUISITE INFORMATION.

All information needed to be disclosed by these rules will be set out conspicuously and closely associated with the statements to which such information relates or under appropriate captions of such prominence that it will not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

## 012.FORM AND CONTENT OF ADVERTISEMENTS.

The format and content of an advertisement of an accident or sickness insurance policy will be sufficiently complete, not misleading, and clear to avoid deception.

## 013.ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE.

01. Prohibitions. Deceptive words, phrases or illustrations banned:
    a. No advertisement will contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" or similar words and phrases, in a manner that exaggerates any benefits beyond the terms of the policy.
    b. An advertisement will not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit. Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions should fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.
    c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility will use words or phrases that have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

d. No advertisement of a hospital or other similar facility benefit will advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro - rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit needs to appear in the advertisement.

e. No advertisement of a policy covering only one (1) disease or a list of specified diseases will imply coverage beyond the terms of the policy.

f. An advertisement for a policy providing benefits for specified illnesses only, or for specified accidents only, will clearly and conspicuously in prominent type, state the limited nature of the policy. The statement will be in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

g. No advertisement of a direct response insurance product will imply that because "no insurance agent will call and no commissions will be paid to agents" that it is a "low cost plan," or use other similar words.

h. No advertisement will contain or use words or phrases such as, "Medicare supplement"; "Medigap"; "this policy will help fill some of the gaps that Medicare leaves out"; or similar words and phrases, unless the policy is issued in compliance with IDAPA 18.04.10.

i. An advertisement will clearly state the type of insurance coverage being offered.

02. Exceptions, Reductions and Limitations.

a. When an advertisement refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the 1oss for which such benefit is payable, it will also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

b. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement that is subject to the requirements of the preceding paragraph will disclose the existence of such periods.

c. An advertisement will not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to describe the applicability of any exceptions and reductions.

03. Pre-Existing Conditions.

a. An advertisement subject to the requirements of Subsection 013.02 will, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The term "pre-existing condition" without an appropriate definition or description will not be used.

b. When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy will state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement will disclose that a medical examination is needed.

c. When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form will contain a question or statement that reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature.

**014.NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLATION AND TERMINATION.**

When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it will disclose the provisions relating to renewability, cancellation and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner that will not minimize or render obscure the qualifying conditions.

**015.TESTIMONIALS OR ENDORSEMENTS BY THIRD PARTIES.**

01. Testimonials. Testimonials used in advertisements will be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of this chapter.

02. Disclosure of Financial Interest. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact will be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact will be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This chapter does not require disclosure of union "scale" wages set by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements requires disclosure of such compensation.

03. Limitations and Restrictions. An advertisement will not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact will be disclosed in the advertisement.

04. Retention of Data. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information is retained by the insurer for inspection for a period of four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

**016.USE OF STATISTICS.**

01. Requests for Use of Statistical Information. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy cannot use irrelevant facts, and cannot be used unless it accurately reflects all relevant facts. Such an advertisement will not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans will specifically so state.

02. Restrictions on Representations. An advertisement will not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and cannot be used.
03. Source of Statistics. The source of any statistics used in an advertisement will be identified in such advertisement.

**017. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES.**

01. Disclosure Requirements. When a choice of the amount of benefits is referred to, an advertisement will disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.
02. Disclosure Based on Combination of Policies. When an advertisement refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement will disclose that such benefits are provided only through a combination of such policies.

**018. DISPARAGING COMPARISONS AND STATEMENTS.**

An advertisement will not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and will not disparage competitors, their policies, services or business methods, and will not disparage or unfairly minimize competing methods of marketing insurance.

**019. JURISDICTION LICENSING AND STATUS OF INSURER.**

01. Restrictions on Licensing Jurisdiction. An advertisement intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed will not imply licensing beyond those limits.
02. Restrictions on Endorsements. An advertisement will not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States Government.

**020. IDENTITY OF INSURER.**

01. Name of Insurer to Be Identified. The name of the actual insurer is clearly identified and the policy or policies advertised is identified by form number or otherwise described. An advertisement will not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that, without disclosing the name of the actual insurer.
02. Identity of Insurer Not to Be Misrepresented. No advertisement can use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combinations of words, symbols, or physical materials used by agencies of the federal government or of this state, or appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

**021. GROUP OR QUASI-GROUP IMPLICATIONS.**

An advertisement of a particular policy will not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

**022. INTRODUCTORY, INITIAL OR SPECIAL OFFERS.**

01. Restrictions on Introductory, Initial or Special Offers.
    a. An advertisement of an individual policy will not represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement cannot contain phrases describing an enrollment period as "special," "limited," or similar words.
    b. An enrollment period during which a particular insurance product may be purchased on an individual basis cannot be offered within this state unless there has been a lapse of not less than three (3) months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement will indicate the date by which the applicant need mail the application, which is not less than ten (10) days and not more than forty (40) days from the date that such enrollment period is advertised for the first time. This chapter applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one (1) insurer. It is inapplicable to solicitations of employees or members of a particular group or association that would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one (1) insurer" includes all the affiliated companies of a group of insurance companies under common management or control.
    c. This chapter prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.
    d. The phrase "a particular insurance product" in paragraph(s) of this Section means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; and increase or decrease in the dollar amounts of benefits; and increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy will not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.
02. Restrictions on Reduced Initial Premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement will not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium.
03. Restriction on Special Awards. Special awards, such as a "safe drivers' award" will not be used in connection with advertisements of accident or accident and sickness insurance.

**023. STATEMENTS ABOUT AN INSURER.**
An advertisement will not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement will not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

**024. ENFORCEMENT PROCEDURES.**
Each insurer will maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement that will indicate the manner and extent of distribution and the form number of any policy advertised. Such file is subject to regular and periodical inspection by this Department. All such advertisements will be maintained in said file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever period is longer.

**025. FILING FOR PRIOR REVIEW.**
The Director may, at their discretion, require the filing of any accident and sickness insurance advertising material for review prior to use.

# IDAPA 18.04.08 – Individual and Group Supplementary Disability Insurance Minimum Standards Rule

## 000.LEGAL AUTHORITY.

Title 41, Chapters 2 and 42, Idaho Code.

## 001.TITLE AND SCOPE.

01. Title. IDAPA 18.04.08, "Individual and Group Supplementary Disability Insurance Minimum Standards Rule."
02. Purpose. The purpose of this chapter is to implement Title 41, Chapters 21, 22, 34, and 42, Idaho Code, to standardize and simplify the terms and coverages of individual and group supplementary disability insurance, to facilitate public understanding and comparison of coverage, to eliminate provisions 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 such insurance.
03. Applicability and Scope. This chapter applies to all individual and group policies and certificates providing hospital confinement indemnity, disability income protection, accident only, specified disease, specified accident, or limited benefit health coverage, referred to collectively in this chapter as "supplementary disability insurance," offered, delivered, issued for delivery, or renewed in this state or to a resident of this state, unless specifically exempted.
    a. This chapter applies to dental plans and vision plans only as specified.
    b. This chapter applies to group supplementary plans whether issued to supplement a group health benefit plan, or as a supplementary plan that pays benefits regardless of other coverage.
    c. This chapter does not apply to:
        i. Individual policies or contracts issued pursuant to a conversion privilege under a group policy or certificate.
        ii. Policies issued to employees or members as additions to franchise plans.
        iii. Medicare supplement policies subject to Title 41, Chapter 44, Idaho Code, Medicare Supplement Insurance Minimum Standards.
        iv. Long-term care insurance policies subject to Title 41, Chapter 46, Idaho Code, Long Term Care Insurance.
        v. Civilian Health and Medical Program of the Uniformed Services, Title 10, Chapter 55, of the United States Code, (CHAMPUS) supplement insurance policies.
        vi. Individual or group major medical expense coverage, including short-term coverage.

## 002.INCORPORATION BY REFERENCE.

01. Copies. May be obtained from the Idaho Department of Insurance.
02. Documents Incorporated by Reference. The following Outlines of Coverage and notices are incorporated by reference from the April 1999 version of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act:
    a. Hospital Confinement Indemnity Coverage.
    b. Disability Income Protection Coverage.
    c. Accident Only Coverage.
    d. Specified Disease.
    e. Specified Accident.
    f. Limited Benefit Health Coverage.
    g. Dental Plans.
    h. Vision Plans.
    i. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (direct sales).
    j. Notice to Applicant Regarding Placement of Accident and Sickness Insurance (other than direct sales).

## 003. -- 009.(RESERVED)

## 010.DEFINITIONS.

01. 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, and does not provide coverage for non-accidents.
02. Dental Coverage. "Dental Coverage" means a policy or certificate that primarily provides benefits for dental expenses.
03. 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.
04. 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, meaning the benefit is a fixed dollar amount per day of confinement, regardless of the expenses incurred.
05. Limited Benefit Health Coverage. "Limited Benefit Health Coverage" means a policy or certificate that provides benefits that are less than the minimum standards under Sections 035 through 039 of this chapter.
06. Major Medical Expense Coverage. "Major Medical Expense Coverage" means a policy of accident and sickness insurance that provides hospital, medical and surgical expense coverage.
07. 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.
08. Specified Disease Coverage. "Specified Disease Coverage" means a policy or certificate that pays benefits only after the diagnosis of a specifically named disease or diseases.
09. Vision Coverage. "Vision Coverage" means a policy or certificate that primarily provides benefits for vision expenses.

**Reference:** ***IDAPA 18.04.08 (continued)***

**011.POLICY DEFINITIONS AND TERMS.**

Except as provided in this chapter, an insurance policy or certificate to which this chapter applies will not include definitions more restrictive than the following:

01. Accident. "Accident," "accidental injury," and "accidental" is to employ "result" language and does 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.
    a. "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.
    b. It may exclude injuries for which benefits are provided:
        i. Under workers' compensation, employers' liability, or similar law; or
        ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or
        iii. For injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.
02. Convalescent Nursing Home. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" is to be defined in relation to its status, facility and available services.
    a. Such home or facility is to:
        i. Be operated pursuant to law;
        ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested;
        iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
        iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and
        v. Maintain a daily medical record of each patient.
    b. The definition of the home or facility may provide that the term will not be inclusive of:
        i. A home, facility or part of a home or facility used primarily for rest;
        ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or
        iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.
03. 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 that meets all of the following requirements:
    a. It is primarily engaged in providing home health care services;
    b. Its policies are established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse);
    c. A physician or a registered nurse provides supervision of home health care services;
    d. It maintains clinical records on all patients; and
    e. It has a full-time administrator.
04. 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.
05. Hospital. "Hospital" is to 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.
    a. The hospital may:
        i. Be an institution licensed to operate as a hospital pursuant to law;
        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
        iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses.
    b. The term will not be inclusive of the following, unless the facility otherwise meets the qualifications set forth at Paragraph 011.05.a. of this Section:
        i. Convalescent homes or, convalescent, rest, or nursing facilities;
        ii. Facilities affording primarily custodial, educational, or rehabilitory care;
        iii. Facilities for the aged, drug addicts, or alcoholics; or
        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.
06. Mental Disorders or Nervous Disorders. "Mental disorders" or "nervous disorders" includes neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.
07. Nurse. "Nurse" may be 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 necessitates 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.
08. One Period of Confinement. "One (1) period of confinement" means consecutive days of inhospital 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 (3) times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days.

09. Partial Disability. "Partial disability" is 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.
10. Preexisting Condition. "Preexisting condition" is:
    a. 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;
    b. 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
    c. A pregnancy existing on the effective date of coverage.
11. Provider. "Provider" means a person or entity that, as necessary, is licensed to provide health care or related services.
12. Residual Disability. "Residual disability" is 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 necessary. A policy that provides for residual disability benefits may impose a qualification period, during which the insured needs to 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.
13. Sickness or Illness. "Sickness or illness" means sickness or disease of an insured person that presents itself after the effective date of insurance and while the insurance is in force. It may exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law."
14. Total Disability. "Total disability" is in accordance with the following limitations:
    a. 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.
    b. Total disability may be defined in relation to the inability of the person to perform duties but is not to be based solely upon an individual's inability to:
        i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or
        ii. Engage in a training or rehabilitation program.
    c. An insurer may stipulate 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 stipulate care by a physician other than the insured or a member of the insured's immediate family.

**012. -- 019.(RESERVED)**

**020.BANNED POLICY PROVISIONS.**

01. Probationary or Waiting Period. Except as provided in Subsection 011.10 pertaining to the definition of a preexisting condition or Paragraph 038.02.e. of this chapter regarding specified disease coverage, a policy or certificate will not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy or certificate. Accident policies will not contain probationary or waiting periods.
02. Additional Coverage as Dividend. A policy or rider for additional coverage will 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 will not be issued for an initial term of less than six (6) months.

a. The initial renewal subsequent to the issuance of a policy or rider as a dividend will 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.

03. Return of Premium or Cash Value Benefit. A disability income policy, accident only policy, limited benefit policy, specified disease 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 subject to this chapter is to 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.
04. Exclusions. A policy or certificate will not limit or exclude coverage by type of illness, accident, treatment or medical condition, except that a policy or certificate may include one (1) or more of the following limitations or exclusions:
    a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
    b. Mental or emotional disorders, alcoholism and drug addiction;
    c. Pregnancy, except for complications of pregnancy;
    d. Illness, treatment or medical condition arising out of:
        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;
        ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
        iii. Professional aviation for wage or profit; and
        iv. With respect to disability income protection policies, incarceration.
    e. Cosmetic surgery, except that "cosmetic surgery" will not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications or complications related to a cosmetic procedure;
    f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

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;
h. Benefits 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;
i. Dental care or treatment;
j. Eye glasses and the examination for the prescription, or fitting of them;
k. Rest cures, custodial care, transportation, and routine physical examinations;
l. Territorial limitations;
m. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device.
n. Missed or canceled 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;
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.

05. Preexisting Conditions.
a. Except as provided in this subsection, a policy will not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the coverage due to a preexisting condition.
b. For policies other than disability income or specified disease, an individual carrier will not modify a policy with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for specifically named preexisting diseases or conditions otherwise covered by the policy.

**021. -- 029. (RESERVED)**

**030. MINIMUM STANDARDS FOR BENEFITS.**

01. Minimum Standards. The following minimum standards for benefits are prescribed for the categories of coverage noted in Sections 035 through 040 of this chapter. Such an insurance policy or certificate will not be offered, delivered, issued for delivery, or renewed in this state or to a resident of this state unless it meets the minimum standards for the specified categories or the Director finds that the policies or contracts are allowable as limited benefit health insurance, and the outline of coverage complies with the applicable model outline of coverage for each category of coverage. An insurer will deliver an outline of coverage to an applicant or enrollee with the sale.
02. Renewability. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy or certificate will 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 will provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, will become the insured.
a. The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" will not be used without further explanatory language in accordance with the disclosure requirements of Section 101 of this chapter.
b. The terms "noncancellable" or "noncancellable and 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 set forth in the policy, 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.
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.
d. Except as provided in Subsection 030.02 of this chapter, (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, 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.

03. Age and Durational Requirements. In a policy covering both husband and wife, the age of the younger spouse will be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this provision will not mandate 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 to the age or for the durational period as specified in the policy.
04. Accidental Death and Dismemberment Coverage. When accidental death and dismemberment coverage is part of the policy coverage offered under the contract, the insured will have the option to include all insureds under the coverage.
05. Military Service Limitations. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy will provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

06. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits will 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.
07. Convalescent or Extended Care Benefits. Policies providing convalescent or extended care benefits following hospitalization will 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.
08. Coverage of Dependents. A policy's coverage will continue for a dependent child who is incapable of self-sustaining employment due to intellectual disability or physical 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 stipulate that the company receives due proof of the incapacity within thirty-one (31) days of the date 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 intellectual disabilities or physical disabilities need meet the requirements of Sections 41-2139 and 41-2203, Idaho Code.
09. Expenses of Live Donor. A policy providing coverage for the recipient in a transplant operation will 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.
10. Recurrent Disabilities. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities will not specify that a recurrent disability be separated by a period greater than six (6) months.
11. Accidental Death and Dismemberment. Accidental death and dismemberment benefits will 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, will not require the loss to commence less than thirty (30) days after the date of accident, nor will 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.
12. Specific Dismemberment Benefits. Specific dismemberment benefits will not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.
13. Extension of Benefits. Termination of the policy will be without prejudice to a continuous loss that commenced while the policy or certificate was in force. Such extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.
14. Fractures or Dislocations. A policy providing coverage for fractures or dislocations will not provide benefits only for "full or complete" fractures or dislocations.

**031. -- 034.(RESERVED)**

**035. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.**

01. Minimum Standards for Benefits. The following minimum standards apply:
    a. Provides daily benefits for hospital confinement on an indemnity basis in an amount not less than forty dollars ($40) per day; and
    b. Provides benefits for not less than thirty-one (31) days during each period of confinement for each person insured under the policy.
    c. Benefits will be paid regardless of other coverage.
02. Banned 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 will not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.
    c. Policies or certificates which include additional indemnity coverage on a basis other than per day of confinement will not be considered hospital confinement coverage.
03. Disclosure Provisions.
    a. All hospital confinement indemnity policies and certificates will 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 will 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."
    c. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act."

**036. DISABILITY INCOME PROTECTION COVERAGE.**

01. Minimum Standards for Benefits. The following minimum standards apply to disability income protection coverage:
    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);
    b. Contains an elimination period no greater than:
        i. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less;
        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
        iii. Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury;
    c. Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits is put into effect because of an increase in Social Security or similar benefits during a benefit period.

02. Banned Policy Provisions.
    a. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be applied.
    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 will not require the loss to commence less than thirty (30) days after the date of accident, nor will 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. No reduction in benefits will be put into effect because of an increase in Social Security or similar benefits during a benefit period.
    e. No policy or certificate may use activities of daily living to define partial or total disability.
03. Disclosure Provisions. All disability income protection policies will 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."

**037. ACCIDENT ONLY COVERAGE.**

01. Minimum Standards for Benefits. The following minimum standards apply to accident only coverage:
    a. Accidental death and double dismemberment amounts under the policy or certificate are at least one thousand dollars ($1,000);
    b. A single dismemberment amount is at least five hundred dollars ($500); and
    c. Benefits for disability, hospital or medical care will be as defined in the policy or certificate.
02. Banned Policy Provisions. Accident only policies or certificates will not contain probationary or waiting periods.
03. Disclosure Provisions.
    a. All accident-only policies and certificates will 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 will prominently set forth in the outline of coverage the circumstances under which benefits are payable that are less than the maximum amount payable under the policy or certificate.
    c. Accident-only policies or certificates that provide coverage for hospital or medical care will contain the following statement in addition to the Notice to Buyer: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

**038. SPECIFIED DISEASE COVERAGE.**

01. Minimum Standards for Benefits. The following minimum standards apply to specified disease coverage:
    a. Coverage for cancer only or cancer in conjunction with other conditions or diseases needs to meet the standards of Paragraphs 01.e., 01.f., or 01.g. of this section.
    b. Coverage for specified diseases other than cancer meets the standards of Paragraphs 01.c., 01.d., or 01.g. of this section.
    c. Non-cancer Coverages with Deductible. 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.
    d. Non-cancer Coverages without Deductible. 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.
    e. Cancer-only or Combination Expense Policies. 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 for 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 will be prescribed in writing by the insured person's attending physician, who will approve the program prior to its start. The physician certifies that hospital confinement would be otherwise necessary. 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;

xi. Therapy, including physical, speech, hearing, and occupational therapy;

xii. Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances;

xiii. Prosthetic devices including wigs and artificial breasts;

xiv. Nursing home care for non-custodial services; and

xv. Reconstructive surgery when deemed necessary by the attending physician.

f. Per Diem Cancer Coverages. Cancer coverages on a per diem indemnity basis includes:

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.

g. Lump Sum Indemnity Coverage. Lump sum indemnity coverage for any specified disease will be 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.

i. Dollar benefits may only be in increments of one thousand dollars ($1,000).

ii. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts will 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.

h. Hospice Care. Hospice care is optional and does not cover non-terminally ill patients. If offered, it will provide:

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).

i. Nursing Home Care. Benefits for skilled nursing home confinement or the receipt of home health care are optional. If offered, it will 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, but no more restrictive than under Medicare;

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, but no more restrictive than under Medicare; and

iii. Benefit payments 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.

02. Banned Policy or Certificate Provisions. 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 apply to specified disease coverages in addition to all other requirements imposed by this chapter. In cases of conflict the following govern:

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

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

c. Notwithstanding any other provision of this chapter, specified disease policies will 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.

d. Individual accident and sickness policies containing specified disease coverage will be guaranteed renewable.

e. No policy issued pursuant to this Section contains 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.

f. Except for lump sum indemnity coverage, 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.

g. Benefits will be paid regardless of other coverage.

h. After the effective date of the coverage (or applicable waiting period, if any) benefits begins 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 is not to be less than ninety (90) days prior to the diagnosis.

i. Policies providing expense benefits will 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."

j. Preexisting condition will 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."

k. 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.

03. Disclosure Provisions.

a. An application or enrollment form for specified disease coverage will 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 request the applicant's or enrollee's signature.

b. All specified disease policies and certificates will 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. Outlines of coverage delivered in connection with "Specified Disease" to persons eligible for Medicare by reason of age will 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."

d. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act."

**039.SPECIFIED ACCIDENT COVERAGE.**

01. Minimum Standards for Benefits. The following minimum standards apply to specified accident coverage:

a. 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; and

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

02. Banned Policy or Certificate Provisions. Specified accident policies will not contain probationary or waiting periods.

03. Disclosure Provisions.

a. Specified accident policies or certificates that provide coverage for hospital or medical care will contain the following statement in addition to the Notice to Buyer: "This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

b. All specified accident policies and certificates will 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."

**040.LIMITED BENEFIT HEALTH COVERAGE.**

01. Minimum Standards.

a. Limited Benefit Health Coverage will not be offered, delivered, issued for delivery, or renewed in this state or to a resident of this state unless approved by the Director prior to use.

b. A policy covering a single specified disease or combination of diseases will not be offered for sale as "limited benefit" coverage.

c. Section 040 does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in Title 41, Chapter 46, Idaho Code, "Long-Term Care Insurance" and Title 41, Chapter 44, Idaho Code, "Medicare Supplement Insurance Minimum Standards."

02. Disclosure Provisions.

a. All limited benefit health policies and certificates will 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."

b. An insurer will deliver to persons eligible for Medicare any notice prescribed under IDAPA 18.04.10, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act."

**041.DENTAL COVERAGE.**

01. Disclosure Provisions. Dental coverage will include the following disclosures;

a. All applications will 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 will 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."

**042.VISION COVERAGE.**

01. Disclosure Provisions. Vision coverage will include the following disclosures;

a. All applications will 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 will 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."

**043. -- 100.(RESERVED)**

**101.DISCLOSURE PROVISIONS.**

01. General Rules for Disclosure Provisions.
    a. All applications for coverages specified in Sections 035 through 040 will 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 limited benefits. Review your (policy) (certificate) carefully.
    b. Each policy or certificate subject to this chapter will include a renewal, continuation or nonrenewal provision. The language or specification of the provision needs to be consistent with the type of contract to be issued. The provision will be appropriately captioned, will appear on the first page of the policy or certificate, and will 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.
    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 will necessitate signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a commensurable increase in premium during the policy term is to be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is prescribed 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.
    d. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge will be set forth in the policy or certificate.
    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 will include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.
    f. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations will appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."
    g. All policies and certificates, will have a notice prominently printed on the first page of the policy or certificate stating in substance that the policyholder or certificate holder will 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.
    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 will be prominently set forth in the outline of coverage.
    i. If a policy or certificate contains a conversion privilege, it will comply, in substance, with the following:
        i. The caption of the provision will be "Conversion Privilege" or words of similar import.
        ii. The provision will 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
        iii. The provision will 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.

02. Outline of Coverage Requirements. Outlines of coverage prescribed under this chapter will conform to the model outlines of coverage incorporated herein in Section 002 of this chapter, and set forth at the Idaho Department of Insurance website.
    a. An insurer will 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 prescribed by Section 41-4205, Idaho Code. If an application is made by electronic means, an insurer will deliver an outline of coverage on the next working day the completed application is received, and delivery may be made by the following methods regardless of the form of application:
        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 necessitate revision of the outline, a substitute outline of coverage properly describing the policy or certificate will accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) boldface point 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."
    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 will be filed with the Director.

**102. -- 200.(RESERVED)**

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

01. Application Form. An application form will 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.
02. Prescribed Notice. Notices prescribed under this chapter will conform to the model outlines of coverage incorporated herein in Section 002 of this chapter, and set forth at the Idaho Department of Insurance website. Upon determining that a sale will involve replacement, an insurer, or its agent will 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 will deliver to the applicant upon issuance of the policy, the notice described in this section

**Link to Model Outlines of Coverage.**

# 18.04.10 – MEDICARE SUPPLEMENT INSURANCE STANDARDS 000.LEGAL AUTHORITY.

Title 41, Chapters 2 and 44, Idaho Code.

**001. SCOPE.**

a. Except as specifically provided in Sections 046, 051, 066, and 077, this chapter applies to:
   i. All Medicare supplement policies delivered or issued for delivery in this state; and
   ii. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

b. This chapter does not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization.

**002. INCORPORATION BY REFERENCE.**

This chapter incorporates by reference Appendixes A (Refund Calculation and Calculation of Benchmark forms Model Regulation 651 pages 651-94 to 651-97), B (Form for Reporting Medicare Supplement Policies, page 651-98), and C (Disclosure Statements pages 651-99 to 651-108), and all other outlines of coverage and specific plan designs of the National Association of Insurance Commissioners (NAIC) Model Regulation 651 (pages 651-42 to 651-85) implementing the Medicare supplement insurance minimum standards (2018). The Model Regulation is available from the National Association of Insurance Commissioners and from the Idaho Department of Insurance.

**003. -- 009.(RESERVED)**

**010. DEFINITIONS.**

01.Applicant.
   a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and
   b. In the case of a group Medicare supplement policy, the proposed certificate holder.

02.Bankruptcy. A Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

03.Continuous Period of Creditable Coverage. The period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

04.Creditable Coverage.
   a. With respect to an individual, coverage of the individual provided under any of the following:
      i. A group health plan;
      ii. Health insurance coverage;
      iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
      iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
      v. Title 10, Chapter 55, United States Code (CHAMPUS);
      vi. A medical care program of the Indian Health Service or of a tribal organization;
      vii. A state health benefits risk pool;
      viii. A health plan offered under Title 5, Chapter 89, United States Code (Federal Employees Health Benefits Program);
      ix. A public health plan as defined in federal regulation; and
      x. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
   b. Creditable coverage does not include one (1) or more, or any combination of, the following:
      i. Coverage only for accident or disability income insurance, or any combination thereof;
      ii. Coverage issued as a supplement to liability insurance;
      iii. Liability insurance, including general liability insurance and automobile liability insurance;
      iv. Workers' compensation or similar insurance;
      v. Automobile medical payment insurance;
      vi. Credit-only insurance;
      vii. Coverage for on-site medical clinics; and
      viii. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
   c. Creditable coverage does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are not an integral part of the plan:
      i. Limited scope dental or vision benefits;
      ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
      iii. Such other similar, limited benefits as are specified in federal regulations.
   d. Creditable coverage does not include the following benefits if offered as independent, noncoordinated benefits:
      i. Coverage only for a specified disease or illness; and
      ii.Hospital indemnity or other fixed indemnity insurance.
   e. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance:
      i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
      ii. Coverage supplemental to the coverage provided under Title 10, Chapter 55, United States Code; and
      iii. Similar supplemental coverage provided to coverage under a group health plan.
   f. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addressed separate, noncoordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, credible coverage has been addressed in an interim final rule (62 Fed. Reg. At 16960-16962 (April 8, 1997)) issued by the Secretary of Health and Human Services, pursuant to HIPAA, and may be addressed in subsequent regulations.

05.Employee Welfare Benefit Plan. A plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

06.Insolvency. When an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

07.Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes:

a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

07. Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes:
    a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
    b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and
    c. Medicare Advantage private fee-for-service plans.
08. Medicare Supplement Policy. As defined in Section 41-4402 and in addition, "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C. Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act; provided, however, that under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) need to comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act.
09. Pre-Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.
10. 1990 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.
11. 2010 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance with an effective date for coverage issued on or after June 1, 2010.
12. Secretary. The Secretary of the United States Department of Health and Human Services.

**011. POLICY DEFINITIONS AND TERMS.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

01. Accident, Accidental Injury, or Accidental Means. To employ "result" language and does 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.

a. The definition will not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

b. The definition may provide that injuries cannot include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless banned by law.

02. Benefit Period or Medicare Benefit Period. Will not be defined more restrictively than as defined in the Medicare program.
03. Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility. Will not be defined more restrictively than as defined in the Medicare program.
04. Health Care Expenses. For purposes of Section 051, expenses of managed care organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.
05. Hospital. Defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.
06. Medicare. Is defined in the policy and certificate, substantially as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof."
07. Medicare Eligible Expenses. Expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
08. Physician. Will not be defined more restrictively than as defined in the Medicare program.
09. Sickness. Will not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

**012. POLICY PROVISIONS.**

01. Medicare Supplement Policy. Except for permitted preexisting condition clauses as described in Paragraph 022.01.a., no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.
02. Waivers. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.
03. Duplicate Benefits. No Medicare supplement policy or certificate in force in this state may contain benefits which duplicate benefits provided by Medicare.

**013. -- 021.(RESERVED) 022.BENEFIT STANDARDS FOR 2010 STANDARDIZED BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized benefit plan for sale on or after June 1, 2010. Benefit standards applicable to policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain in effect.

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.
    a. A Medicare supplement policy or certificate cannot exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate will not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

b. A Medicare supplement policy or certificate will not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate provides that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy is guaranteed renewable.

i. The issuer cannot cancel or nonrenew the policy solely on the ground of health status of the individual.

ii. The issuer cannot cancel or nonrenew the policy for any reasons other than nonpayment of premium or material representation.

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 022.01.e.v., the issuer offers certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(1) Provides for continuation of the benefits contained in the group policy; or

(2) Provides for benefits that meet the requirements of this Subsection.

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer:

(1)Offers the certificateholder the conversion opportunity described in Subparagraph 022.01.e.iii.; or

(2)At the option of the group policyholder, offers the certificate holder continuation of coverage under the group policy.

v. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy offers coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy cannot exclude preexisting conditions that would have been covered under the group policy being replaced.

f. Terminations of a Medicare supplement policy or certificate need to be without prejudice to any continuous loss that commenced while the policy was in force. Such extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. A Medicare supplement policy or certificate provides that benefits and premiums under the policy or certificate may be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate is automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

ii. Each Medicare supplement policy provides that benefits and premiums under the policy may be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy is automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within (90) days after the date of the loss and pays the premium attributed to the period, effective as of the date of termination of enrollment in the group health plan.

iii. Reinstitution of coverages as described in Subparagraphs 022.01.g.i. and 022.01.g.ii.;

(1)Does not provide for any waiting period with respect to treatment of preexisting conditions;

(2)Provides for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(3)Provides for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

h. An issuer makes available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02.

i. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 022.04.h. and 022.04.i.), then the issuer makes available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph 022.01.h., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 022.04.c.) or standardized benefit Plan F (as described in Paragraph 022.04.e.).

j. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section are offered for sale in this state, except as may be permitted in Subsection 022.05 and in Section 031.

k. Benefit plans are uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010. Each benefit is structured in accordance with the format provided in Subsections 022.02 and 022.03; or, in the case of plans K or L, in Paragraphs 022.04.h. and 022.04.i. and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of benefit.

l. In addition to the benefit plan designations prescribed in Paragraph 022.01.k., an issuer may use other designations to the extent permitted by law.

02. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans makes available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.
    a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;
    b. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
    c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider will accept the issuer's payment as payment in full and will not bill the insured for any balance;
    d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
    e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
    f. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

03. Standards for Additional Benefits. The following additional benefits are included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 024.
    a. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
    b. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
    c. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
    d. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
    e. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
    f. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

04.Make-up of 2010 Standardized Benefit Plans.
    a. Standardized benefit Plan A includes only the following: The basic (core) benefits as defined in Subsection 022.02.
    b. Standardized benefit Plan B includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Paragraph 022.03.a.
    c. Standardized benefit Plan C includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.d., and 022.03.f., respectively.
    d. Standardized benefit Plan D includes only the following: The basic (core) benefit (as defined in Subsection 022.02), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively.
    e. Standardized [regular] Plan F includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively.
    f. Standardized Plan F with High Deductible includes only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 022.04.f.ii.
        i. The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively.
        ii .The annual deductible in Plan F with High Deductible consists of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and is in addition to any other specific benefit deductibles. The basis for the deductible is one thousand five hundred dollars ($1,500) and is adjusted annually from 1999 by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).
    g. Standardized benefit Plan G includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.e., and 022.03.f., respectively. Effective January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

h. Standardized Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following:
i. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period.
ii. Part A Hospital Coinsurance ninety-first through one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;
iii. Part A Hospitalization After One Hundred Fiftieth Day: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider accepts the issuer's payment as payment in full and will not bill the insured for any balance;
iv. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x.
v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x.
vi. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x.
vii. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x.
viii. Part B Cost Sharing: Except for coverage provided in Subparagraph 022.04.h.ix., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x.
ix. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
x. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-ofpocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.
i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following:
i. The benefits described in Subparagraphs 022.04.h.i. through 022.04.h.iii., and 022.04.h.ix.
ii. The benefits described in Subparagraphs 022.04.h.iv. through 022.04.h.viii. but substituting seventy-five percent (75%) for fifty percent (50%); and
iii. The benefit described in Subparagraph 022.04.h.x. but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

j. Standardized Medicare supplement Plan M includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.b., 022.03.c., and 022.03.f., respectively.

k. Standardized Medicare supplement Plan N includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively, with copayments in the following amounts:
i. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
ii. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment is waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

05. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits cannot adversely impact the goal of Medicare supplement simplification. New or innovative benefits cannot include an outpatient prescription drug benefit. New or innovative benefits cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

**023. -- 024. (RESERVED) 025. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies need to comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 022.

01. Benefit Requirements. The standards and requirements of Section 024 apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:
a. Standardized benefit Plan C is redesignated as Plan D and provides the benefits contained in Paragraph 022.04.c. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

b. Standardized benefit Plan F is redesignated as Plan G and provides the benefits contained in Paragraph 022.04.e. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.
c. Standardized benefit plans C, F, and F with High Deductible will not be offered to individuals newly eligible for Medicare on or after January 1, 2020.
d. Standardized benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and provides the benefits contained in Paragraph 022.04.f., but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible.
e. The reference to Plans C or F contained in Paragraph 022.01.i. is deemed a reference to Plans D or G for purposes of this section.

02. Applicability to Certain Individuals. This section applies only to individuals that are newly eligible for Medicare on or after January 1, 2020:
a. By reason of attaining age sixty-five (65) on or after January 1, 2020; or
b. By reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

03. Guaranteed Issue for Eligible Persons. For purposes of Subsection 041.05, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) is deemed a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of Subsection 025.01.

04. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection 022.04.

**026. -- 035. (RESERVED) 036. OPEN ENROLLMENT.**

01. Offer of Coverage.
a. An issuer cannot deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with:
i. The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.
ii. The first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or
iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration.
b. Each Medicare supplement policy and certificate currently available from an issuer is made available to all applicants who qualify under Paragraph 036.01.a. without regard to age.

02. Treatment of Preexisting Conditions.
a. If an applicant qualifies under Subsection 036.01 and applies during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer cannot exclude benefits based on a preexisting condition.
b. If the applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer reduces the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary specifies the manner of the reduction under this Subsection.
c. Except as provided in Paragraphs 036.02.a. and 02.b., and Sections 041 and 081, nothing in this chapter prevents the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was diagnosed during the six (6) months before the coverage became effective.

**037. -- 040. (RESERVED) 041. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.**

01. Guaranteed Issue.
a. Eligible persons are those individuals described in Subsection 041.02 who seek to enroll under the policy during the period specified in Subsection 041.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.
b. With respect to eligible persons, an issuer cannot deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 041.05 that is offered and is available for issuance to new enrollees by the issuer, cannot discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and will not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 041.02:
a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;
b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
i. The certification of the organization or plan under this part has been terminated;
ii. The organization has terminated or discontinued providing the plan in the area in which the individual resides;

iii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

iv. The individual demonstrates, in accordance with guidelines established by the Secretary:

(a) That the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(b) The organization, or agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(c) The individual meets such other exceptional conditions as the Secretary may provide.

c. The individual is enrolled with:

i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

iv. An organization under a Medicare Select policy; and

d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 041.02.b.

e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

ii. Of other involuntary termination of coverage or enrollment under the policy; iii. The issuer of the policy substantially violated a material provision of the policy; or

iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

f. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and

g. The subsequent enrollment under Paragraph 041.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

h. The individual, upon first becoming eligible for benefits under Part A of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 041.05.e.

j. The individual is enrolled in a Medicare Supplement policy, and, on or after March 1, 2022, voluntarily terminates enrollment and enrolls in another Medicare Supplement policy.

03. Guaranteed Issue Time Periods.

a. In the case of an individual described in Paragraph 041.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

b. In the case of an individual described in Paragraphs 041.02.b., 041.02.c., 041.02.f., or 041.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

c. In the case of an individual described in Paragraph 041.02.e., the guaranteed issue period begins on the earlier of:

i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

d. In the case of an individual described in Paragraph 041.02.b. and Subparagraph 041.02.e. iii., and Subparagraph 041.02.e.iv., Paragraph 041.02.f., or 041.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and

e. In the case of an individual described in Paragraph 041.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

f. In the case of an individual described in Subsection 041.02 but not described in the preceding provisions of Subsection 041.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

g. In the case of an individual described in Paragraph 041.02.j., the guaranteed issue period begins on the individual's birthday and ends sixty-three (63) days thereafter.

04. Extended Medigap Access for Interrupted Trial Periods.
    a. In the case of an individual described in Paragraph 041.02.f. (or so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 041.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.f.;
    b. In the case of an individual described in Paragraph 041.02.h. (or so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph 041.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.h.; and c. For purposes of Paragraphs 041.02.f. and 041.02.h., no enrollment of an individual with an organization or provider described in Paragraph 041.02.f. or with a plan or in a program described in Paragraph 041.02.h. may be deemed an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:
    a. Paragraphs 041.02.a. through 041.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer.
    b. Subject to Paragraph 041.05.c., Paragraph 041.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 041.05.a.
    c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 041.05 is:
        i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
        ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;
    d. Paragraph 041.02.h. includes any Medicare supplement policy offered by any issuer.
    e. Paragraph 041.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.
    f. Paragraph 041.02.j. includes any comparable or lesser Medicare policy offered by any issuer. For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Supplement policy or certificate being replaced.

06. Notification Provisions.
    a. At the time of an event described in Subsection 041.02 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, notifies the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated contemporaneously with the notification of termination.
    b. At the time of an event described in Subsection 041.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, notifies the individual of the individual's rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated within ten (10) working days of the issuer receiving notification of disenrollment.

**042. -- 045. (RESERVED)**

**046. STANDARDS FOR CLAIMS PAYMENT.**

01. Compliance. An issuer will comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:
    a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form needed and making a payment determination on the basis of the information contained in that notice;
    b. Notifying the participating physician or supplier and the beneficiary of the payment determination;
    c. Paying the participating physician or supplier directly;
    d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
    e. Paying user fees for claim notices; and
    f. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

02. Certification. Compliance with the requirements set forth in Subsection 046.01 is certified on the Medicare supplement insurance experience reporting form.

**047. -- 050. (RESERVED) 051. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.**

01. Loss Ratio Standards.
    a. A Medicare supplement policy form or certificate form will not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form.
        i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or
        ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization will not include:
i. Home office and overhead costs;
ii. Advertising costs;
iii. Commissions and other acquisition costs; iv. Taxes;
v. Capital costs;
vi. Administrative costs; and vii. Claims processing costs.

c. All filings of rates and rating schedules demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations, at a minimum, account for:
i. Lapse rates;
ii. Medical trend and rationale for trend;
iii. Assumptions regarding future premium rate revisions; and
iv. Interest rates for discounting and accumulating. d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are individual policies.

02. Refund or Credit Calculation.
a. An issuer collects and files with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible on the Department website for each type in a standard Medicare supplement benefit plan.
b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is needed. The refund calculation is done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year is excluded.
c. For policies or certificates issued prior to July 1, 1992, the issuer makes the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992.
d. A refund or credit is made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund includes interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due is made by September 30 following the experience year upon which the refund or credit is based.

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates in this state annually files its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation demonstrates in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration excludes active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage is demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state files with the director, in accordance with the applicable filing procedures of this state:
a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents accompanying the filing need to justify the adjustment.
i. An issuer's adjustments need to produce an expected loss ratio under the policy or certificate that conforms to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein is made with respect to a policy at any time other than upon its renewal date or anniversary date.
ii. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio prescribed by Section 051.
b. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms provides a clear description of the Medicare supplement benefits provided by the policy or certificate.

**052. -- 055. (RESERVED)**

**056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.**

01. Filing of Policy Forms.
a. An issuer cannot deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director.
b. An issuer would file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as prescribed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

02. Filing of Premium Rates.
a. An issuer cannot use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.
b. Except as provided in Subsection 051.03, the insured cannot receive more than one (1) rate increase in any twelve (12) month period.

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization will not include:
i. Home office and overhead costs;
ii. Advertising costs;
iii. Commissions and other acquisition costs; iv. Taxes;
v. Capital costs;
vi. Administrative costs; and vii. Claims processing costs.

c. All filings of rates and rating schedules demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations, at a minimum, account for:
i. Lapse rates;
ii. Medical trend and rationale for trend;
iii. Assumptions regarding future premium rate revisions; and
iv. Interest rates for discounting and accumulating. d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are individual policies.

02. Refund or Credit Calculation.
a. An issuer collects and files with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible on the Department website for each type in a standard Medicare supplement benefit plan.
b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is needed. The refund calculation is done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year is excluded.
c. For policies or certificates issued prior to July 1, 1992, the issuer makes the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992.
d. A refund or credit is made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund includes interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due is made by September 30 following the experience year upon which the refund or credit is based.

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates in this state annually files its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation demonstrates in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration excludes active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage is demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state files with the director, in accordance with the applicable filing procedures of this state:
a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents accompanying the filing need to justify the adjustment.
i. An issuer's adjustments need to produce an expected loss ratio under the policy or certificate that conforms to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein is made with respect to a policy at any time other than upon its renewal date or anniversary date.
ii. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio prescribed by Section 051.
b. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms provides a clear description of the Medicare supplement benefits provided by the policy or certificate.

**052. -- 055. (RESERVED)**

**056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.**

01. Filing of Policy Forms.
a. An issuer cannot deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director.
b. An issuer would file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as prescribed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

02. Filing of Premium Rates.
a. An issuer cannot use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.
b. Except as provided in Subsection 051.03, the insured cannot receive more than one (1) rate increase in any twelve (12) month period.

03. Except as provided in Paragraph 056.03.a., an issuer will not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.
    a. An issuer may offer, with the approval of the director, up to three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases:
    i. The inclusion of new or innovative benefits; ii. The addition of either direct response or agent marketing methods; iii. The addition of either guaranteed issue or underwritten coverage;
    b. For the purposes of Section 056, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.
04. Availability of Policy Form or Certificate. Except as provided in Paragraph 056.04.a., an issuer continuously makes available for purchase any policy form or certificate form. A policy form or certificate form would not be considered available for purchase unless the issuer has actively offered it for sale continuously during the previous twelve (12) months.
    a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer no longer offers for sale the policy form or certificate form in this state.
    b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 056.04.a. will not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.
    c. The sale or other transfer of Medicare supplement business to another issuer is considered a discontinuance for the purposes of Subsection 056.04.
    d. A change in the rating structure or methodology is considered a discontinuance under this Subsection 056.04 unless the issuer complies with the following requirements:
        i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
        ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest.
05. Experience of Policy Forms.
    a. Except as provided in Paragraph 056.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan is combined for purposes of the refund or credit calculation prescribed in Section 051.
    b. Forms assumed under an assumption reinsurance agreement are not combined with the experience of other forms for purposes of the refund or credit calculation.
    c. The experience of all policy forms or certificate forms for standardized benefit plans of the same type is combined for purposes of the rate change filing. Generally, any applicable percentage increase is filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type.
06. Age Rating. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter:
    a. It is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. For issue-age rated policies:
        i. For an individual who is sixty-five (65) years of age or older, the filed rate for any given age will not exceed the rate for any higher issue-age, similarly rated individual; and
        ii. For an individual who is under sixty-five (65) years of age, the premium is no greater than one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65) similarly rated individual, while the individual's attained age is less than sixty -five (65). Upon attaining age sixty-five (65), a policyholder with an issueage less than sixty-five (65) is charged the same premium rate as an issue-age sixty-five (65), similarly rated individual.
    b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age or issue age of an insured, subscriber or participant as a basis for premiums. For such community-rated policies:
        i. For an individual who is eligible for Medicare Part B only due to disability or end stage renal disease, the premium is no greater than one hundred fifty percent (150%) of the premium for an enrollee otherwise eligible for Medicare Part B; and
        ii. Upon attaining Medicare Part B eligibility due to age, a policyholder who was previously eligible for Medicare Part B only due to disability or end stage renal disease is to be charged the same premium rate as an individual eligible for Medicare Part B due to age.
07. Rating by Area and Gender. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose.
08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, sold to residents of this State on or after January 1, 2018:
    a. Any rate adjustments are uniform between 1990 Standardized and later Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type.
    b. The rating by the issuer does not differentiate on the basis of the reason for eligibility for Medicare Part B, except for an individual, at any given age, described at Subparagraph 056.06.b.i.
09. Discriminatory Discount or Other Payment Practices. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter:
    a. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 036, or guaranteed issue, per Section 041, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue.
    b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer to require application or policy fees or to vary premium rates based on payment terms including, without limitation, payment method or frequency of payment.
    c. Nothing in this Subsection is construed to limit the ability of an issuer of a Medicare supplement policy or certificate to apply a discount or underwriting factor for:
        i. Multiple Medicare Supplement policies issued to individuals residing within the same household, or;
        ii. Non-smoking or non-tobacco use.

**057. -- 060. (RESERVED) 061. PERMITTED COMPENSATION ARRANGEMENTS.**

01. Commissions. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. An issuer or other entity may not vary commission or otherwise pay commission differentials based upon variables such as age, guarantee issue status, or on any other basis.
02. Compensation in Subsequent Years. The commission or other compensation provided in subsequent renewal years needs to be the same as that provided in the second year or period and be provided for no fewer than five (5) renewal years.
03. Renewal Compensation. No issuer or other entity provides compensation to its agent or other producers and no agent or producer receives compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.
04. Compensation. For purposes of Section 061, compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

**062. -- 065. (RESERVED) 066. DISCLOSURE PROVISIONS.**

01. General Rules.
    a. Medicare supplement policies and certificates includes a renewal or continuation provision. The language or specifications of the provision is consistent with the type of contract issued. The provision is appropriately captioned and appears on the first page of the policy, and includes any reservation by the issuer of the right to change premiums.
    b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is needed to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy requires a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing and signed by the insured, unless the benefits are prescribed by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy.
    c. Medicare supplement policies or certificates do not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.
    d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
    e. Medicare supplement policies and certificates have a notice prominently printed on the first page of the policy or certificate or attached thereto, stating in substance that the policyholder or certificateholder has the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
    f. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed jointly by the National Association of Insurance Commissions and the Centers for Medicare & Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide is made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates. Except in the case of direct response issuers, delivery of the Guide will be made to the applicant at the time of application and acknowledgment of receipt of the Guide is obtained by the issuer. Direct response issuers deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.
    g. For the purposes of Section 066, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.
02. Notice Requirements.
    a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer notifies its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice will:
        i. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
        ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.
    b. The notice of benefit modifications and any premium adjustments is in outline form and in clear and simple terms so as to facilitate comprehension.
    c. The notices cannot contain or be accompanied by any solicitation.
03. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Notice Requirements. Issuers comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
04. Outline of Coverage Requirements for Medicare Supplement Policies.
    a. Issuers provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, obtain an acknowledgment of receipt of the outline from the applicant; and
    b. If an outline of coverage is provided at the time of application and the Medicare supplement 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 accompanies the policy or certificate when it is delivered and contains the following statement, in no less than twelve (12) point 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 and the coverage originally applied for has not been issued."
    c. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage is in the language and format prescribed below in no less than twelve (12) point type. All plans are shown on the cover page, and the plans that are offered by the issuer are prominently identified. Premium information for plans that are offered are shown on the cover page or immediately following the cover page and is prominently displayed. The premium and mode is stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant are illustrated.

05. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.
    a. Any accident and sickness insurance policy or certificate other than Medicare supplement policy and policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Paragraph 001.02.b., issued for delivery in this state to persons eligible for Medicare notifies insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice is either printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice is no less than twelve (12) point type and contains the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."
    b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph 066.04.a. disclose, using the applicable NAIC Model Regulation as incorporated by reference in Section 002 and referenced as Appendix C. The disclosure statement is provided as a part of, or together with, the application for the policy or certificate.

**067. – 070. (RESERVED) 071. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.**

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.
02. Statements.
    a. You do not need more than one (1) Medicare supplement policy.
    b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
    c. You may be eligible for benefits under Medicaid and not need a Medicare supplement policy.
    d. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You need to request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
    e. If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or unionbased group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
    f. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).
03. Agents. Agents will list any other health insurance policies they have sold to the applicant. a. List policies sold which are still in force. b. List policies sold in the past five (5) years which are no longer in force.
04. Direct Response Issuer. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, is returned to the applicant by the insurer upon delivery of the policy.
05. Notice Regarding Replacement of Medicare Supplement Coverage. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, furnishes the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, is provided to the applicant and an additional signed copy is retained by the issuer. A direct response issuer delivers to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.
06. SHIBA and Consumer Assistance Link. The notice prescribed in Subsection 071.05 for an issuer is provided in the NAIC Model Regulation as incorporated by reference in Section 002 of this rule, which includes NAIC Appendixes A, B, and C and all other outlines of coverage and specific plan designs which can be accessed on the Idaho Department of Insurance website. To obtain a copy of the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance.

**072. FILING REQUIREMENTS FOR ADVERTISING.**

An issuer provides a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by the director.

**073. STANDARDS FOR MARKETING.**

01. Issuer. An issuer, directly or through its producers:
    a. Establishes marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
    b. Establishes marketing procedures to assure excessive insurance is not sold or issued.
    c. Displays prominently by type, stamp, or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses."
    d. Inquires and makes every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
    e. Establishes auditable procedures for verifying compliance with this Subsection 073.01.

02. Banned Acts and Practices. In addition to the practices banned in Title 41, Chapter 13,Idaho Code, the following acts and practices are banned:
   a. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
   b. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. 03. Banned Terms. The terms "Medicare supplement," "Medigap," "Medicare wrap-around," and words of similar import cannot be used unless the policy is issued in compliance with this chapter.

**074. -- 075. (RESERVED) 076. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.**
In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent makes reasonable efforts to determine the appropriateness of a recommended purchase or replacement. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is banned. An issuer cannot issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

**077. REPORTING OF MULTIPLE POLICIES.**
01. Reporting. On or before March 1 of each year, an issuer reports the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate: a. Policy and certificate number, and b. Date of issuance.
02. Grouping by Individual Policyholder. The items set forth above need to be grouped by individual policyholder.

**078. – 080. (RESERVED)**

**081. PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.**
01. Waiving of Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer waives any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.
02. Replacing Policy. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy does not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate.

**082. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.**
01. Banned Provisions. An issuer of a Medicare supplement policy or certificate:
   a. Does not deny or condition the issuance of effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and
   b. Does not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.
02. Denial of Coverage. Nothing in Subsection 082.01 is construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:
   a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
   b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual will not also be used as genetic information about other group members and to further increase the premium for the group).
03. Genetic Testing. An issuer of a Medicare supplement policy or certificate cannot request or require an individual or a family member of such individual to undergo a genetic test.
04. Payment. Subsection 082.03 does not preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection 082.01.
05. Information. For purposes of carrying out Subsection 082.04, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
06. Allowed Genetic Testing. Notwithstanding Subsection 082.03, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
   a. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or rules for the protection of human subjects in research.
   b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:
      i. Compliance with the request is voluntary; and
      ii. Non-compliance will have no effect on enrollment status or premium or contribution amounts.
   c. No genetic information collected or acquired under Subsection 082.06 is used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
   d. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under Subsection 082.06, including a description of the activities conducted.
   e. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under Subsection 082.06.
   f. An issuer of a Medicare supplement policy or certificate cannot request, require, or purchase genetic information for underwriting purposes.
   g. An issuer of a Medicare supplement policy or certificate cannot request, require or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.
   h. If an issuer of Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, such request, requirement, or purchase is not considered a violation of Paragraph 082.06.g. if such request, requirement, or purchase is not in violation of Paragraph 082.06.f.

07. Definitions. For the purposes of this section only;
   a. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.
   b. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
   c. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.
   d. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
   e. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
   f. "Underwriting purposes" means:
      i. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
      ii. The computation of premium or contribution amounts under the policy;
      iii. The application of any preexisting condition exclusion under the policy; and
      iv. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**083. -- 999. (RESERVED)**

# 18.04.11 – Long-Term Care Insurance Minimum Standards

**000.LEGAL AUTHORITY.**
Title 41, Chapters 2 and 46, Idaho Code.

**001.TITLE AND SCOPE.**
01. Title. IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards."
02. Purpose. The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.
03. Scope and Applicability. Except as specifically provided, this chapter applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state; certain provisions of this chapter apply only to qualified long-term care insurance. Additionally, this chapter is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:
    a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
    b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or
    c. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

**002.INCORPORATION OF DOCUMENTS BY REFERENCE.**
01. Forms. Documents incorporated by reference may be obtained from the Idaho Department of Insurance website.
02. Documents Incorporated by Reference. This chapter incorporates by reference the following documents, appendices, and attachments of the National Association of Insurance Commissioners (NAIC) Long- Term Care Model Regulation. The Model Regulation is available from the NAIC and from the Idaho Department of Insurance.
    a. Rescission Reporting Form for Long-Term Care, Appendix A.
    b. Personal Worksheet, Appendix B.
    c. Things You Should Know Before You Buy Long-Term Care Insurance, Appendix C.
    d. Suitability Letter, Appendix D.
    e. Claims Denial Reporting Form, Appendix E.
    f. Instructions, Appendix F.
    g. Replacement and Lapse Reporting Form, Appendix G.
    h. Outline of Coverage.
    i. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Attachment I.
    j. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance, Attachment II.

**003. -- 009.(RESERVED)**

**010.DEFINITIONS.**
For the purpose of this rule, the following definitions apply in addition to those found in Title 41, Chapter 46, Idaho Code.
01. Exceptional Increase. Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products.
    a. Except as provided in Section 025, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases.
    b. The director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.
    c. The director, in determining that the necessary basis for an exceptional increase exists, will determine any potential offsets to higher claims costs.
02. Incidental. As used in Subsection 025.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values are measured as of the date of issue.
03. Qualified Actuary. Means a member in good standing of the American Academy of Actuaries.

**011.POLICY DEFINITIONS.**
For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state may use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions are to satisfy definitions as amended by the U.S. Treasury Department and the following requirements.
01. Activities of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring.
02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.
03. Adult Day Care. A program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.
04. Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
05. Cognitive Impairment. A deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
06. Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
08. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
09. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

10. Home Health Care Services. Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.
11. Mental or Nervous Disorder. Limited to neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
12. Personal Care. The provision of hands-on services to assist an individual with activities of daily living.
13. Similar Policy Forms. Means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows:
    a. Institutional long-term care benefits only;
    b. Non-institutional long-term care benefits only; or
    c. Comprehensive long-term care benefits.
14. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Defined in relation to the level of skill prescribed, the nature of the care and the setting in which care need be delivered.
15. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
16. Transferring. Moving into or out of a bed, chair, or wheelchair.
17. All Providers of Services. All providers of services including but not limited to Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, Personal Care Facility, Specialized Care Providers, Assisted Living Facility, and Home Care Agency is defined in relation to the services and facilities prescribed to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it also states what requirements a provider need meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

**012.POLICY PRACTICES AND PROVISIONS.**

01. Renewability. The terms "guaranteed renewable" and "noncancellable" cannot be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 014 of this rule.
    a. A policy issued to an individual cannot contain renewal provisions other than "guaranteed renewable" or "noncancellable."
    b. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
    c. The term "noncancellable" may be used only when the insured has the right to continue the longterm care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
    d. The term "level premium" may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy.
    e. In addition to the other requirements of Subsection 011.01, a qualified long-term care insurance contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended.
02. Limitations and Exclusions. A policy cannot be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
    a. Preexisting conditions or diseases;
    b. Mental or nervous disorders; however, this does not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
    c. Alcoholism and drug addiction;
    d. Illness, treatment, or medical condition arising out of:
        i. War or act of war (whether declared or undeclared);
        ii. Participation in a felony, riot, or insurrection;
        iii. Service in the armed forces or units auxiliary thereto;
        iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
        v. Aviation (this exclusion applies only to non-fare-paying passengers).
    e. Treatment provided in a government facility (unless prescribed by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;
    f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
    g. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
    h. Subsection 011.02 is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:
        i. When the state other than the state of policy issue does not have the provider licensing, certification or registration prescribed in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
        ii When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 011.02.h. "state of policy issue" means the state in which the individual policy or certificate was originally issued.
        iii. Subsection 011.02 is not intended to prohibit territorial limitations.
03. Extension of Benefits. Termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

04. Continuation or Conversion.
    a. Group long-term care insurance issued in this state on or after the effective date of Section 011 provides covered individuals with a basis for continuation or conversion of coverage.
    b. For the purposes of Section 011, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director makes a determination as to the substantial equivalency of benefits, and in doing so, takes into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
    c. For the purposes of Section 011, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.
    d. For the purposes of Section 011, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the director, in making a determination as to the substantial equivalency of benefits, takes into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
    e. Written application for the converted policy is made and the first premium due, if any, is paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy is issued effective on the day following the termination of coverage under the group policy and is renewable annually.
    f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy is calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
    g. Continuation of coverage or issuance of a converted policy is mandatory, except where:
        i. Termination of group coverage resulted from an individual's failure to make any prescribed payment of premium or contribution when due; or
        ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:
            (1) Providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided by the terminating coverage; and
            (2) The premium for which is calculated in a manner consistent with the requirements of Subsection 011.04.f.
    h. Notwithstanding any other provision of Section 011, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision is only included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
    i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, cannot exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
    j. Notwithstanding any other provision of Section 011, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
    k. For the purposes of Section 011 a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.
05. Discontinuance and Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer offers coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
    a. Will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
    b. Cannot vary or depend on the individual's health or disability status, claim experience or use of long-term care services.
06. Premium Changes.
    a. The premium charged to an insured cannot increase due to either:
        i. The increasing age of the insured at ages beyond sixty-five (65); or
        ii. The duration the insured has been covered under the policy.
    b. The purchase of additional coverage is not considered a premium rate increase, but for purposes of the calculation prescribed under Section 032, the portion of the premium attributable to the additional coverage is added to and considered part of the initial annual premium.
    c. A reduction in benefits is not considered a premium change, but for purpose of the calculation prescribed under Section 032, the initial annual premium is based on the reduced benefits. Section 013 Page 9
07. Electronic Enrollment for Group Policies.
    a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by a producer or insurer is satisfied if:
        i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information is provided to the enrollee;
        ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and
        iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained.
    b. The insurer makes available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

**013.UNINTENTIONAL LAPSE.**

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance, as a protection against unintentional lapse, complies with the following:
    a. No individual long-term care policy or certificate is issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation cannot constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation will provide space clearly designated for listing at least one (1) person. The designation includes each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver states: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer notifies the insured of the right to change this written designation, no less often than once every two (2) years.
    b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection 013.01.a. need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates clearly indicates the payment plan selected by the applicant.
    c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate can lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection 013.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is given by first class United States mail, postage prepaid; and notice cannot be given until thirty (30) days after a premium is due and unpaid. Notice is deemed to have been given as of five (5) days after the date of mailing.

02. Reinstatement. In addition to the requirement in Subsection 013.01, a long-term care insurance policy or certificate includes a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option is available to the insured if requested within five (5) months after termination and allows for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

**014.REQUISITE DISCLOSURE PROVISIONS.**

01. Renewability. Individual long-term care insurance policies will contain a renewability provision.
    a. The provision is appropriately captioned, appears on the first page of the policy, and clearly states that the coverage is guaranteed renewable or noncancellable. This provision cannot apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.
    b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, includes a statement that the premium rates may change.

02. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy requires signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing signed by the insured, except if the increased benefits or coverage are prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy, rider or endorsement.

03. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import includes a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations appears as a separate paragraph of the policy or certificate and is labeled as "Preexisting Condition Limitations."

05. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those banned in Section 41- 4605(4)(b)(i), Idaho Code, sets forth a description of the limitations or conditions, including any prescribed number of days of confinement, in a separate paragraph of the policy or certificate and labels such paragraph "Limitations or Conditions on Eligibility for Benefits."

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is prescribed at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement is prominently displayed on the first page of the policy or rider and any other related documents. Subsection 014.06 cannot apply to qualified long-term care insurance contracts.

07. Benefit Triggers. Activities of daily living and cognitive impairment is used to measure an insured's need for long-term care and is described in the policy or certificate in a separate paragraph and is labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers need to be explained. If these triggers differ for different benefits, explanation of the trigger accompanies each benefit description. If an attending physician or other specified person needs to certify a certain level of functional dependency to be eligible for benefits, this too needs to be specified.

08. Qualified Contracts. A qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract includes a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is not intended to be a qualified long-term care insurance contract.

10. Requisite Disclosure of Rating Practices to Consumers.
    a. Subsection 014.10 applies as follows:
        i. Except as provided in Subsection 014.10.a.ii., Subsection 014.10 applies to any long-term care policy or certificate issued in this state on or after July 1, 2001.
        ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 014.10 applies on the policy anniversary following January 1, 2002.
    b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers provide all of the information listed in Subsection 014.10.b. to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer provides all information listed in Subsection 014.10.b. to the applicant no later than at the time of delivery of the policy or certificate.
        i. A statement that the policy may be subject to rate increases in the future;
        ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;
        iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and
        iv. A general explanation for applying premium rate or rate schedule adjustments that includes a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 014.10.b.ii., if the premium rate or rate schedule is changed.
    c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:
        i. The policy forms for which premium rates have been increased;
        ii. The calendar years when the form was available for purchase; and
        iii. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
    d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
    e. An insurer has the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to acquisition.
    f. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of Subsection 014.10 or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company includes the disclosure of that rate increase in accordance with Subsection 014.10.c.
    g. If the acquiring insurer in Subsection 014.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from insurers referenced in Subsection 014.10.f., the acquiring insurer will make all disclosures prescribed by Subsection 014,10.c., including disclosure of the earlier rate increase referenced in Subsection 014.10.f.
    h. An applicant signs an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure prescribed under Subsections 014.10.b. and 014.10.c. If because of the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant signs no later than at the time of delivery of the policy or certificate.
    i. An insurer uses the forms in Appendices B and F to comply with the disclosure requirements of Subsection 014.10.b. and Subsection 014.10.h.
    j. An insurer provides notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice includes the information prescribed by Subsection 014.10.b., when the increase is implemented.

**015.PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.**

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue contains clear and unambiguous questions designed to ascertain the health condition of the applicant.
02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it will also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would be denied, then the policy or certificate cannot be rescinded for that condition.
03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue:
    a. The following language is set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.
    b. The following language, or language substantially similar to the following, is set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: "Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)."
    c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer obtains one (1) of the following:
        i. A report of a physical examination;
        ii. An assessment of functional capacity;
        iii. An attending physician's statement; or
        iv. Copies of medical records.
04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) is delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and annually furnishes this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A.

**016.MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.**

01. Limitations or Exclusions. A long-term care insurance policy or certificate cannot, if it provides benefits for home health care or community care services, limit or exclude benefits:
    a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
    b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;
    c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;
    d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of their licensure or certification;
    e. By excluding coverage for personal care services provided by a home health aide;
    f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that prescribed by the eligible service;
    g. By requiring that the insured or claimant have an acute condition before home health care services are covered;
    h. By limiting benefits to services provided by Medicare-certified agencies or providers; or
    i. By excluding coverage for adult day care services.
02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, provides total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement cannot apply to policies or certificates issued to residents of continuing care retirement communities.
03. Maximum Coverage. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

**017.REQUIREMENT TO OFFER INFLATION PROTECTION.**

01. Inflation Protection Offer. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers will offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) of the following:
    a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);
    b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as long as the option for the previous period has not been declined. The amount of the additional benefit is no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
    c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.
    d. With respect to inflation protection for a Partnership policy only:
        i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy will provide some level of automatic compound annual inflation protection;
        ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy will provide some level of automatic annual inflation protection; and
        iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not prescribed to) provide some level of inflation protection.
02. Group Offer. Where the policy is issued to a group, the prescribed offer in Subsection 017.01 is made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603(4)(d), Idaho Code, other than to a continuing care retirement community, the offering is made to each proposed certificateholder.
03. Requirements for Life Insurance Policies. The offer in Subsection 017.01 above is not prescribed of life insurance policies or riders containing accelerated long-term care benefits.
04. Outline of Coverage. Insurers include the following information in or with the outline of coverage:
    a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shows benefit levels over at least a twenty (20) year period.
    b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
    c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.
05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these benefits continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.
06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases includes an offer of a premium which the insurer expects to remain constant. The offer discloses in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant. 07. Rejection of Offer. Inflation protection as provided in Subsection 017.01 is included in a longterm care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as prescribed in Subsection 017.07. The rejection may be either in the application or on a separate form. The rejection is considered a part of the application and states: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection (signature line: _____)."

**018.REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.**

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.
    a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations?
    b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
        i. If so, with which company?
        ii. If that policy lapsed, when did it lapse?
    c. Are you covered by Medicaid?
    d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?
02. Other Policy Disclosures. Producers list any other health insurance policies they have sold to the applicant.
    a. List policies sold that are still in force.
    b. List policies sold in the past five (5) years that are no longer in force.
03. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer furnishes the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of the notice is retained by the applicant and an additional copy signed by the applicant is retained by the insurer. The prescribed notice is in a form based on the NAIC Model Regulation Attachment I.
04. Direct Response Solicitations. Insurers using direct response solicitation methods deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The prescribed notice is in a form based on the NAIC Model Regulation Attachment II.
05. Notice of Replacement. Where replacement is intended, the replacing insurer notifies, in writing, the existing insurer of the proposed replacement. The existing policy is identified by the insurer, name of the insured and policy number or address including zip code. Notice is made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.
06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care comply with Section 018 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer complies with the replacement requirements of IDAPA 18.03.04, "Replacement of Life Insurance and Annuities." If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer complies with both the long-term care and the life insurance replacement requirements.

**019.REPORTING REQUIREMENTS.**

01. Maintenance of Producer Records. Every insurer maintains records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the number of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales, in the format of Appendix G.
02. Producers Experiencing Lapses and Replacements. Every insurer reports annually by June 30 the ten percent (10%) of its producers with the greatest percentages of lapses and replacements as measured by Subsection 019.01.
03. Purpose of Reports. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.
04. Lapsed Policies. Every insurer reports annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
05. Replacement Policies. Every insurer reports annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.
06. Claims Denied. Every insurer reports annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition, in the format of Appendix E.
07. Policies and Reports. For purposes of Section 019, "policy" means only long-term care insurance and "report" means on a statewide basis.
    a. Policy means only long-term care insurance;
    b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
    c. Denied means the insurer refused to pay a claim for any reason; and
    d. Report means on a statewide basis.
08. Filing. Reports prescribed under Section 019 are filed with the Director.

**020.LICENSING.**

No producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Producer Licensing.

**021.DISCRETIONARY POWERS OF DIRECTOR.**
The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
02. Residential Care Community. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
03. Other Insurance Products. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

**022.RESERVE STANDARDS.**

01. Acceleration of Benefits Under Life Policies. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits are determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life Insurance. Claim reserves will also be established in the case when the policy or rider is in claim status.
02. Decrement Models. Reserves for policies and riders subject to Section 022 should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event can the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.
03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table is certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to Section 022, due regard is given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:
    a. Definition of insured events;
    b. Covered long-term care facilities;
    c. Existence of home convalescence care coverage;
    d. Definition of facilities;
    e. Existence or absence of barriers to eligibility;
    f. Premium waiver provision;
    g. Renewability;
    h. Ability to raise premiums;
    i. Marketing method;
    j. Underwriting procedures;
    k. Claims adjustment procedures;
    l. Waiting period;
    m. Maximum benefit;
    n. Availability of eligible facilities;
    o. Margins in claim costs;
    p. Optional nature of benefit;
    q. Delay in eligibility for benefit;
    r. Inflation protection provisions; and
    s. Guaranteed insurability option.
04. Benefits Not Covered in Section 022. When long-term care benefits are provided other than as in Subsection 022.01 above, reserves are determined in accordance with Section 41-608, Idaho Code, "Reserve for Disability Insurance."

**023.LOSS RATIO.**
Section 023 applies to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 024 and 025 of this chapter.

01. Expected Loss Ratios. Benefits under long-term care insurance policies are reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration is given to all relevant factors, including:
    a. Statistical credibility of incurred claims experience and earned premiums;
    b. The period for which rates are computed to provide coverage;
    c. Experienced and projected trends;
    d. Concentration of experience within early policy duration;
    e. Expected claim fluctuation;
    f. Experience refunds, adjustments or dividends;
    g. Renewability features;
    h. All appropriate expense factors;
    i. Interest;
    j. Experimental nature of the coverage;
    k. Policy reserves;
    l. Mix of business by risk classification; and
    m. Product features such as long elimination periods, high deductibles and high maximum limits.
02. Policies That Accelerate Benefits. Subsection 023.01 cannot apply to life insurance policies that accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:
    a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance.
c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41- 4605(11), Idaho Code.
i. Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation.
d. An actuarial memorandum is filed with the insurance department that includes:
i. A description of the basis on which the long-term care rates were determined;
ii. A description of the basis for the reserves;
iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
iv. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any;
v. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
vi. The estimated average annual premium per policy and the average issue age;
vii. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
viii. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

**024.FILING REQUIREMENT.**
Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it files with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.
01. Initial Filing Requirements.
a. Subsection 024.01 applies to any long-term care policy issued in this state on or after July 1, 2001.
b. An insurer will provide the information listed in Subsection 024.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale.
c. A copy of the disclosure documents prescribed in Section 014.
d. An actuarial certification consisting of at least the following:
i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration;
iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.
e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted; and
iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 024.02 based on a standard age distribution; and
vii. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or,
viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.
02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration includes either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.
a. In the event the director requests additional information under this provision, the period referred to in Subsection 024.01.b. of this section does not include the period of time during which the insurer is preparing the requested information.

**025.PREMIUM RATE SCHEDULE INCREASES.**
01. Premium Rate Increase Notice. An insurer provides notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and includes:
a. Information prescribed by Section 014.
b. Certification by a qualified actuary that:
i. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and
ii. The premium rate filing is in compliance with the provisions of this Section 025.
02. Actuarial Memorandum. The actuarial memorandum justifying the rate schedule change request includes:
a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:
i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date are provided separately;
ii. The projections include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase;
iii. The projections demonstrate compliance with Subsection 025.03; and

iv. For exceptional increases;
(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
(2) In the event the director determines as provided in Subsection 010.09.c. that offsets may exist, the insurer uses appropriate net projected experience.

b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse.

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary.

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates.

e. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and sufficient information for review of the premium rate schedule increase by the director.

03. Premium Rate Schedule Increases. All premium rate schedule increases are determined in accordance with the following requirements:

a. Exceptional increases provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits.

b. Premium rate schedule increases are calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

i. The accumulated value of the initial earned premium times fifty eight percent (58%);
ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and
iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 025.03.b.iii. on an earned basis.

c. In the event that a policy form has both exceptional and other increases, the values in Subsections 025.03.b.ii. and 025.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts.

d. All present and accumulated values used to determine rate increases use the maximum valuation interest rate for contract reserves. The actuary discloses as part of the actuarial memorandum the use of any appropriate averages.

04. Projections Filed for Review. For each rate increase that is implemented, the insurer files for review by the director updated projections, as defined in Subsection 025.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by this Subsection 025.04 are provided to the policyholder in lieu of filing with the director.

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 025.02.a., are filed for review by the director every five (5) years following the end of the prescribed period in Subsection 025.04. For group insurance policies that meet the conditions in Subsection 025.13, the projections prescribed by Subsection 025.05 are provided to the policyholder in lieu of filing with the director.

06. Actual and Projected Experience. If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of the premium specified in Subsection 025.03, the director may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or
i. Other measures to reduce the difference between the projected and actual experience.

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 025.02.d. and 025.02.e., if applicable.

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer files:

a. A plan, subject to director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 025.08 may be applied; and

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 025.03 had the greater of the original anticipated lifetime loss ratio or fiftyeight percent (58%) been used in the calculations described in Subsections 025.03.b.i. and 025.03.b.iii.

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director reviews, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated:

a. The rate increase is not the first rate increase requested for the specific policy form or forms;

b. The rate increase is not an exceptional increase; and

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

d. In the event significant adverse lapse has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer will;

i. Be subject to the approval of the director;
ii. Be based on actuarially sound principles, but not be based on attained age; and
iii. Provide that the maximum benefits under any new policy accepted by an insured is reduced by comparable benefits already paid under the existing policy.

e. The insurer maintains the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase is limited to the lesser of:
i. The maximum rate increase determined based on the combined experience; and
ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

09. Persistent Practice of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 025.08 of this section, prohibit the insurer from either of the following:
a. Filing and marketing comparable coverage for a period of up to five (5) years; or
b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

10. Exceptions. Subsection 025.01 and 025.09 does not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 010.12, if the policy complies with all of the following provisions:
a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance;
ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities;
iii. IDAPA 18.03.03, Subsection 018.02, "Variable Contracts."

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605 (10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage.

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes:
a. A description of the basis on which the long-term care rates were determined;
b. A description of the basis for the reserves;
c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
d. A description and a table of each actuarial assumption used. For expenses, an insurer will include percent of premium dollars per policy and dollars per unit of benefits, if any;
e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
f. The estimated average annual premium per policy and the average issue age;
g. A statement as to whether underwriting is performed at the time of application. The statement indicates whether underwriting is used and, if used, the statement includes a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement indicates whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
h. A description of the effect of the long-term care policy provision on the prescribed premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status.

13. Exceptions for Association Plans. Premium Rate Schedule Increases Subsections 025.06 and 025.08 cannot apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where:
a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or
b. The policyholder, and not the certificateholders, pay a material portion of the premium, which cannot be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

**026.FILING REQUIREMENTS FOR ADVERTISING.**

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state provides a copy of any longterm care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all advertisements are retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement cannot be reasonably applied.

**027.STANDARDS FOR MARKETING AND PRODUCER TRAINING.**

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its producers, will:
a. Establish marketing procedures and producer training requirements to assure that any marketing activities, including any comparison of policies by its producers will be fair and accurate.
b. Establish marketing procedures to assure excessive insurance is not sold or issued.
c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy cannot cover all of the costs associated with longterm care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
d. Provide copies of the disclosure forms prescribed in Subsection 014.10.
e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 032.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c.
f. Inquire and make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not prescribed.
g. Establish auditable procedures for verifying compliance with Subsection 027.01.
h. At solicitation, provide written notice to the prospective policyholder and certificateholder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program.
i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 011.01.c. of this chapter.

02. Banned Practices. In addition to the practices banned in Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds, the following acts and practices are banned:
    a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer.
    b. High Pressure Tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
    c. Cold Lead Advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
    d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.
03. Associations. With respect to the obligations set forth in Subsection 027.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling longterm care insurance is to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
    a. The insurer files with the insurance department the following material:
        i. The policy and certificate;
        ii. A corresponding outline of coverage; and
        iii. All advertisements to be utilized.
    b. The association discloses in any long-term care insurance solicitation:
        i. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and
        ii. A brief description of the process under which the policies and the insurer issuing the policies were selected.
    c. If the association and the insurer have interlocking directorates or trustee arrangements, the association discloses that fact to its members.
    d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates reviews and approves the insurance policies as well as the compensation arrangements made with the insurer.
    e. The association also will:
        i. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change;
        ii. Actively monitor the marketing efforts of the insurer and its producers; and
        iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
        iv. Subsections 027.03.e.i. through 027.03.e.iii. cannot apply to qualified long-term care insurance contracts.
    f. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information prescribed in Section 027.
    g. The insurer cannot issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in Section 027.
    h. Failure to comply with the filing and certification requirements of Section 027 constitutes an unfair trade practice in violation of Title 41, Chapter 13, Idaho Code, Trade Practices and Frauds.
04. Producer Training Requirements. An individual cannot sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course and ongoing training every twenty-four (24) months thereafter. The training meets the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.06.04, "Continuing Education."
    a. The one-time training course prescribed by this section is no less than eight (8) hours. In addition to the one-time training course, an individual who sells, solicits, or negotiates long-term care insurance completes the ongoing training prescribed by this Subsection 027.04, which is no less than four (4) hours every twenty four (24) months.
    b. The training prescribed under Subsection 027.04.a. consists of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to:
        i. State and federal regulations and requirements and the relationship between qualified state longterm care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid;
        ii. Available long-term care services and providers;
        iii. Changes or improvements in long-term care services or providers;
        iv. Alternatives to the purchase of private long-term care insurance;
        v. The effect of inflation on benefits and the importance of inflation protection; and
        vi. Consumer suitability standards and guidelines.
    c. The training prescribed by Subsection 027.04. cannot include any sales or marketing information, materials, or training, other than those prescribed by state and federal law.
    d. Insurers subject to this rule obtain verification that a producer receives training prescribed by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer maintains records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as prescribed by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care including Medicaid in this state. These records are maintained in accordance with the state's record retention requirements and made available to the director upon request.
    e. The satisfaction of these training requirements in any state satisfy the training requirements of this state.

**028.SUITABILITY.**

01. Life Insurance Policies That Accelerate Benefits. Section 028 cannot apply to life insurance policies that accelerate benefits for long-term care.
02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the "issuer") will:
    a. Develop and use suitability standards to determine whether the purchase or replacement of longterm care insurance is appropriate for the needs of the applicant;
    b. Train its producers in the use of its suitability standards; and
    c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director.
03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer;
    a. The producer and issuer develop procedures that take the following into consideration:
        i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
        ii. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
        iii. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
    b. The issuer and producer, if involved, make reasonable efforts to obtain the information set out in Subsection 028.03. The efforts include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer contains, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet is filed with the director.
        i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance website.
    c. A completed personal worksheet is returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
    d. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is banned.
04. Appropriateness. The issuer uses the suitability standards it has developed pursuant to Section 028 in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
05. Use of Standards. Producers use the suitability standards developed by the issuer in marketing long-term care insurance.
06. Disclosure Form. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" is provided. The form is in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type.
07. Rejection and Alternatives. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer sends the applicant a letter similar to the NAIC Model Regulations, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification is made part of the applicant's file.
08. Reporting. The issuer reports annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

**029.PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.**

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer waives any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

**030.AVAILABILITY OF NEW SERVICES OR PROVIDERS.**

01. Notification to Policyholder. An insurer notifies the policyholder of the availability of a new longterm care policy that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice is provided within twelve (12) months of the date the new policy is made available for sale in this state.
02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not prescribed for any policy issued prior to the effective date of this Section 030 or to any policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the prescribed premium to add such new services or providers.
03. New Coverage. The insurer makes the new coverage available in one of the following ways:
    a. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
    b. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits are based on premiums paid or reserves held for the prior policy or certificate.
    c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or d. By an alternative program developed by the insurer that meets the intent of Section 030 if the program is filed with and approved by the Director.
04. Proprietary Policy. An insurer is not prescribed to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy are notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030 are considered exchanges and not replacements. These exchanges are not subject to Section 018, and Section 028, and the reporting requirements of Section 019.01. through 019.05. of this rule.
06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the prescribed notification in Subsection 030.01 is made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification is made to each certificateholder.
07. Nothing Prohibits an Insurer From Offering Coverage. Nothing in this Section 030 prohibits an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificate-holder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet eligibility requirements, including underwriting and payment of the prescribed premium to add such new services or providers.
08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits.

**031.RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.**

01. Reduction of Coverage. Every long-term care insurance policy and certificate includes a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
    a. Reducing the maximum benefit; or
    b. Reducing the daily, weekly or monthly benefit amount.
    c. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
02. Implementing a Reduction in Coverage. The provision includes a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage is based on the age used to determine the premiums for the coverage currently in force.
04. Limitations for the Reduction of Coverage. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer provides a written reminder to the policyholder or certificateholder of their right to reduce coverage and premiums in the notice prescribed by Subsection 013.01.c. of this rule.
06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits.
07. Compliance Requirements. The requirements of this Section 031 apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the prescribed provision via amendment or endorsement to the policy.

**032.NONFORFEITURE BENEFIT REQUIREMENT.**

01. Life Insurance Policies That Accelerate Benefits. Section 032 does not apply to life insurance policies or riders containing accelerated long-term care benefits.
02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state satisfies the following:
    a. A policy or certificate offered with nonforfeiture benefits will have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer is the benefit described in Subsection 032.04.e.
    b. The offer is in writing if the nonforfeiture benefit is not described in the Outline of Coverage or other materials given to the prospective policyholder.
03. Contingent Benefit. If the offer prescribed under Section 41-4607, Idaho Code, is rejected, the insurer provides the contingent benefit upon lapse described in Section 032. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. still applies.
04. Rejection of Offer. After rejection of the offer prescribed under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 032, the insurer provides a contingent benefit upon lapse.
    a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate provides either the nonforfeiture benefit or the contingent benefit upon lapse.

b. A contingent benefit on lapse is triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth within Subsection 032.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium

| Issue Age | Percent Increase Over Initial Premium Issue Age | Issue Age | Percent Increase Over Initial Premium Issue Age |
|---|---|---|---|
| 29 and under | 200% | 72 | 36% |
| 30-34 | 190% | 73 | 34% |
| 35-39 | 170% | 74 | 32% |
| 40-44 | 150% | 75 | 30% |
| 45-49 | 130% | 76 | 28% |
| 50-54 | 110% | 77 | 26% |
| 55-59 | 90% | 78 | 24% |
| 60 | 70% | 79 | 22% |
| 61 | 66% | 80 | 20% |
| 62 | 62% | 81 | 19% |
| 63 | 58% | 82 | 18% |
| 64 | 54% | 83 | 17% |
| 65 | 50% | 84 | 16% |
| 66 | 48% | 85 | 15% |
| 67 | 46% | 86 | 14% |
| 68 | 44% | 87 | 13% |
| 69 | 42% | 88 | 12% |
| 70 | 40% | 89 | 11% |
| 71 | 38% | 90 | and over 10% |

i. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise prescribed, policyholders are notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers For A Substantial Premium Increase

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| Under 65 | 50% |
| 65-80 | 30% |
| Over 80 | 10% |

This provision is in addition to the contingent benefit provided by Subsection 032.04.b. and where both are triggered, the benefit provided is at the option of the insured.

c. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b., the insurer:
   i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased;
   ii. Offers to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.; and
   iii. Notifies the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b. is the election of the offer to convert in Subsection 032.04.c.ii. unless the automatic option in Subsection 032.04.d.iii. applies.

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer:
   i. Offers to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that premium payments are not increased;
   ii. Offers to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i.; and
   iii. Notifies the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. is the election of the offer to convert in Subsection 032.04.d.ii. above if the ratio is forty percent (40%) or more.

e. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, in accordance with Subsection 032.04.b. but not Subsection 032.04.b.i. are described in Subsection 032.04.e.
   i. For purposes of this Subsection 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50);
   ii. For purposes of Subsection 032.04.e., the nonforfeiture benefit is of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits are determined as specified in Subsection 032.04.e.iii.;
   iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit cannot be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection 032.04.f.;
   iv. The nonforfeiture benefit begins not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse is effective during the first three (3) years as well as thereafter.

v. Notwithstanding Subsection 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit begins on the earlier of:
(1) The end of the tenth year following the policy or certificate issue date; or
(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
vi. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

f. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

g. There is no difference in the minimum nonforfeiture benefits as prescribed under Section 032 for group and individual policies.

h. For certificates issued on or after the effective date of this Section 032, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section 032 cannot apply.

i. The last sentence Subsection 032.03 and Subsection 032.04.b. and Subsection 032.04.d. applies to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one (1) year after adoption.

i. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of Section 023 or Section 025, whichever is applicable, treating the policy as a whole.

j. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 032.04.b. or 032.04.b.i., a replacing insurer that purchased or assumed a block or blocks of long-term care insurance policies from another insurer calculates the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

k. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts is offered that meets the following requirements:
i. The nonforfeiture provision is appropriately captioned;
ii. The nonforfeiture provision provides a benefit available in the event of a default on the payment of any premiums and states that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts filed for review with the Director for the same contract form; and
iii. The nonforfeiture provision provides at least one (1) of the following:
(1) Reduced paid-up insurance;
(2) Extended term insurance;
(3) Shortened benefit period; or
(4)Other similar offerings approved by the Director.

**033.STANDARDS FOR BENEFIT TRIGGERS.**

01. Conditions of Benefits Payment. A long-term care insurance policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits is not more restrictive than requiring either a deficiency in the ability toperform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 033.02 as long as they are defined in the policy. Activities of daily living includes at least the following as defined in Section 010 and in the policy.
a. Bathing;
b. Continence;
c. Dressing;
d. Eating;
e. Toileting; and
f. Transferring.

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions cannot restrict, and are not in lieu of, the requirements contained in Subsections 033.01 and 033.02.

04. Determinations of Deficiency. For purposes of Section 033 the determination of a deficiency cannot be more restrictive than:
a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

05. Assessments. Assessments of activities of daily living and cognitive impairment are performed by licensed or certified professionals, such as physicians, nurses or social workers.

06. Appeals. Long-term care insurance policies include a clear description of the process for appealing and resolving benefit determinations.

07. Effective Date. The requirements set forth in Section 033 are effective within twelve (12) months of the effective date of the rule and apply as follows:
a. Except as provided in Subsection 033.07.b. the provisions of Section 033 apply to a long-term care policy issued in this state on or after the effective date of the rule.
b. For certificates issued on or after the effective date of Section 033, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which was in force at the time this rule became effective, the provisions of Section 033 do not apply.

**034. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.**

01. Definitions. For purposes of Section 034 the following definitions apply:
    a. Qualified long-term care services means services that meet the requirements of Section 7702B(a)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services and maintenance or personal care services which are prescribed by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
    b. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
        i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
        ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
        c. The term chronically ill individual cannot include an individual meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements.
    d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury.
    e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).
02. The Chronically Ill. A qualified long-term care insurance contract pays for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.
03. Payments and Conditions. A qualified long-term care insurance contract conditions the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment.
04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment prescribed pursuant to Subsection 034.03 are performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.
05. Certifications by Carrier. Certification prescribed pursuant to Subsection 034.03 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification cannot be rescinded and additional certifications cannot be performed until after the expiration of the ninety (90) day period.
06. Appeals. Qualified long-term care contracts include a clear description of the process for appealing and resolving benefit determinations.

**035.STANDARD FORMAT OUTLINE OF COVERAGE.**

Section 035 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage.

01. Format. The outline of coverage is a freestanding document, using no smaller than ten (10) point type. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.
02. Content. The outline of coverage contains no material of an advertising nature.
03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage is published on the Department of Insurance website.

**036.REQUIREMENT TO DELIVER SHOPPER'S GUIDE.**

01. Approved Format. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, is provided to all prospective applicants of a long-term care insurance policy or certificate.
    a. In the case of producer solicitations, a producer will deliver the shopper's guide prior to the presentation of an application or enrollment form.
    b. In the case of direct response solicitations, the shopper's guide will be presented in conjunction with any application or enrollment form.
02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not obligated to furnish the above-referenced guide, but furnish the policy summary prescribed under Section 41- 4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance.

**037.PENALTIES.**

In addition to any other penalties provided by the laws of this state any insurer and any producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.04.11, "Long-Term Care Insurance Minimum Standards," is subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars ($10,000), whichever is greater.

Link to Attachments to Idaho Rule 18.04.11

# 18.06.02 – Producers Handling of Fiduciary Funds

**000.LEGAL AUTHORITY.**
Title 41, Chapter 2 and 10, Sections 41-211, 41-1024, and 41-1025, Idaho Code.

**001.TITLE AND SCOPE.**
01. Title. IDAPA 18.06.02, "Producers Handling of Fiduciary Funds."
02. Scope. This rule will affect "producers," including bail agents who handle funds held in a fiduciary capacity.

**002. -- 009.(RESERVED)**

**010.DEFINITIONS.**
01. Cash Collateral. All funds received as collateral by a producer in connection with a bail bond transaction in the form of cash, check, money order, other negotiable instrument, debit or credit card payment, or other electronic funds transfer, given as security to obtain a bail bond, as referenced in Section 41-1043, Idaho Code.
02. Fiduciary Fund Account. A financial account established to hold fiduciary funds as provided in Section 016.
03. Fiduciary Funds. All premiums, return premiums, premium taxes, funds as collateral, and fees received by a producer. Fiduciary funds include:
    a. All funds paid to a producer for selling, soliciting or negotiating policies of insurance except for those fees recognized by statute as earned by the producer upon receipt which are payable to the producer and not the insurance company, pursuant to Section 41-1030, Idaho Code.
    b. All funds received by a producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or to the producer's employer.
    c. All funds provided to a producer by an insurance company or its agents that are to be paid to a policyholder or claimant pursuant to a contract of insurance.
    d. All checks or other negotiable instruments collected by the producer and made payable to the insurer.
    e. Cash collateral.
04. Receive. To collect or take actual or constructive possession of fiduciary funds. Receiving, includes but is not limited to, taking possession of money, checks, or other negotiable instruments. If fiduciary funds are in the form of a credit or offset on an account or other liability for the benefit of the consumer, without the producer actually taking possession of the funds, then constructive receipt is presumed to have occurred on the due date to the insurer.

**011. -- 013.(RESERVED)**

**014.FIDUCIARY FUND ACCOUNT.**
01. Payable to an Insurer. Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to an insurer as described in Subsection 010.03 are to be remitted to the insurer within the time period set forth in the insurer's terms and conditions, or if not specified, then within twenty-one (21) days of receipt.
02. Payable to a Policyholder. Fiduciary funds that are in the form of a check or another negotiable instrument made payable to a policyholder or claimant as described in Subsection 010.02.c. are to be remitted to the policyholder or claimant within fourteen (14) days of receipt or as specified by the terms of the policy of insurance, the insurer, or applicable law.
03. All Other Fiduciary Funds. All other fiduciary funds received by the producer, except as described under Subsections 014.01 and 014.02 are to be deposited into a fiduciary fund account according to the following schedule:
    a. If in the form of cash, within seven (7) days of receipt, except that, when a producer holds fiduciary funds in the form of cash that exceed two thousand dollars ($2,000), such funds will be deposited within three (3) business days.
    b. If in the form of checks, money orders, other negotiable instruments, debit or credit card payments, or other electronic funds transfer, received or collected by the producer, within seven (7) days of receipt, except that the producer may remit such funds to the following:
        i. Another licensed producer or licensed business entity, subject to Subsection 014.03.b.; or
        ii. A person designated by the insurer who has the obligation to remit the fiduciary funds to the insurer subject to Subsection 014.03.b.
04. Document the Receipt of Fiduciary Funds. A producer who receives fiduciary funds will document the receipt of those funds in sufficient detail to determine, at a minimum, the date received, the name of the payee, and the amount received. If the producer receives cash, including cash collateral, the producer will give the payer a detailed receipt at the time of payment. The receipt needs to indicate that cash was received, the date received, the amount received, the payer's name, the payee's name, the purpose of payment, and any other information important to the transaction. The producer will maintain the receipt for a period of at least five (5) years.

**015.DEPOSIT OF OTHER FUNDS IN ACCOUNT.**
A producer may deposit other additional funds for the sole purpose of:
01. Reserves for Return Premiums. Establishing reserves for payment of return premiums.
02. Funds to Pay Bank Charges. Advancing funds sufficient to pay bank charges.
03. Contingencies. For any contingencies that may arise in the business of receiving and transmitting premium or return premium funds or cash collateral (any such deposit is hereinafter referred to as "voluntary deposit").

**016.TYPES OF ACCOUNTS PERMITTED.**
01. Accounts in Federally Insured Financial Institutions. A producer will maintain the fiduciary funds only in checking accounts, demand accounts, savings accounts or other accounts in a federally insured financial institution.

02. Exceed the Federally Insured Limits. If such funds held exceed the federally insured limits, then in addition to Subsection 016.01, those funds that exceed the federally insured limits may be deposited into the following:
    a. An investment account that invests monies in United States government bonds, United States Treasury certificates or in federally guaranteed obligations;
    b. Money market mutual funds registered with the SEC which are rated AAA by Moody's or AAA by S&P.
03. Separate Fiduciary Funds Account. Nothing in this rule obligates a producer to maintain and hold fiduciary funds in his, her, or its, own separate fiduciary funds account. Each producer is responsible for compliance with the provisions of this rule even if fiduciary funds are maintained in a fiduciary funds account established by another affiliated producer.

**017.ACCOUNT DESIGNATION.**

01. Designation of a Fiduciary Fund. A fiduciary fund account is so designated on the records of the financial institution. The account has a separate account number, a separate check register and its own checks.
02. Trust Fund Account. The phrase, "Trust Fund Account" is displayed on the face of each check drawn on a fiduciary fund account or other similar designation as permitted by the financial institution to identify the checks as being from a fiduciary fund account.

**018.INTEREST EARNINGS.**

A fiduciary fund account may be interest-bearing or an investment account in accordance with Section 016. The producer will maintain records establishing the existence and amount of interest accrued.

**019.PERMISSIBLE DISTRIBUTION OF FIDUCIARY FUNDS**.

Distributions from a fiduciary fund account are to only be made for the following purposes, and in the manner stated:

01. Remit Premiums. To remit premiums to an insurer or an insurer's designee pursuant to a contract of insurance;
02. Return Premiums. To return premiums to an insured or other person or entity entitled to the premiums;
03. Remit Surplus Lines Taxes and Stamping Fees. To remit surplus lines taxes and stamping fees collected to the appropriate state;
04. Reimburse Voluntary Deposits. To reimburse voluntary deposits made by the producer to the extent that the funds in the fiduciary account exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous voluntary deposit.
05. Transfer or Withdraw Accrued Interest. To transfer or withdraw accrued interest to the extent that fiduciary fund account funds exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous interest deposit by the financial institution.
06. Transfer or Withdraw Actual Commissions. To transfer or withdraw actual commissions and those earned fees recognized as earned by the producer, upon receipt, which are payable to the producer, only if the commissions and fees can be matched and identified with funds previously deposited in the fiduciary account.
07. Pay Charges Imposed. To pay charges imposed by the financial institution that directly relate to the operation and maintenance of the fiduciary funds account.
08. Transfer Funds. To transfer funds from one (1) fiduciary fund account to another fiduciary fund account.
09. Return Cash Collateral. To return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, has been discharged.
10. Convert Cash Collateral. To convert cash collateral where the defendant or other responsible party fails to satisfy the obligation of the bail bond and the bail or obligation was not exonerated by the court but instead executed by the court, provided such conversion is compliant with the contract between the producer and the person who deposited the cash collateral.

**020. -- 021.(RESERVED)**

**022.TIMELY DISBURSEMENT OF FIDUCIARY FUNDS.**

In addition to the requirements of Section 014, after receiving fiduciary funds, a producer:

01. Remits Premiums. Remits premiums directly to an insurer or an insurer's designee within the time period set forth in the insurer's terms and conditions, or if not specified, within fourteen (14) days of receipt;
02. Returns Money Received. Returns to the payer the money received as a premium deposit which is retained by the producer or returned to the producer by the insurer to the payer by the earlier of:

a. Fourteen (14) days from the date the premium is received by the producer from the insurer, or
b. Fourteen (14) days from the date the insurer notifies the insurance applicant that coverage has been denied if the producer retained the premium deposit.

03. Refund Received from the Insurer. Issues a refund received from the insurer within fourteen (14) days by disbursing money to the insured or other party entitled thereto by notifying the insured that the refund is being applied to an outstanding amount owed or to be owed by the insured. If the producer is applying the refund to an outstanding amount owed by the insured, the producer obtains the insured's permission and provide the insured a detailed description of the amount owed to which the refund is being applied.
04. Dispute of Entitlement of Funds. If there is a dispute as to entitlement of funds under Subsections 022.01 or 022.03, a producer notifies the parties of the dispute, seeks to resolve it, and documents the steps taken to resolve it.
05. Funds Held for More Than Ninety Days. If fiduciary funds within the scope of Subsections 022.01 or 022.03 are held for more than ninety (90) days, the producer investigates to determine the entitlement to fiduciary funds and pays those fiduciary funds when due to the appropriate person in accordance with this section.
06. Return Cash Collateral. Returns cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, is discharged.

**Reference: IDAPA 18.06.03**

# IDAPA 18.06.03 – Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees

**000.LEGAL AUTHORITY.**
Title 41, Chapter 2, Section 41-211, Idaho Code.

**001.TITLE AND SCOPE.**
01. Title. IDAPA 18.06.03, "Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees."
02. Scope. This chapter applies to all resident and non-resident insurance producers who charge a fee to consumers as authorized by Section 41-1030, Idaho Code.

**002. -- 010.(RESERVED)**

**011.DISCLOSURE REQUIREMENTS.**
01. Before Charging a Fee. Before charging a fee to a consumer, a retail producer will furnish to each consumer a written disclosure statement containing at least the following information:
    a. A description of the nature of the work to be performed by the insurance producer.
    b. The fee schedule and any other expenses that the insurance producer charges, and whether fees may be negotiated.
02. Prior Information Disclosure. A retail producer will disclose information prescribed under this chapter to each consumer to whom a fee will be charged prior to engaging in any act for or on behalf of the consumer.
03. Fee for Intended Services. A retail producer may charge a fee for those services intended to be provided and that are not contingent upon a future event occurring outside of the terms of the insurance contract.
04. Non-Chargeable Fee. A retail producer will not charge a fee for services in connection with statutorily mandated insurance coverage.

Link to the "INSURANCE PRODUCER FEE DISCLOSURE" form

# IDAPA 18.06.04 – CONTINUING EDUCATION

**000. LEGAL AUTHORITY.**
Title 41, Chapters 2, 10, 11, and 58, Sections 41-211, 41-1013, 41-1108, 41-5813, and 41-5820, Idaho Code.

**001. SCOPE.**
This rule prescribes a minimum education in approved subjects that impacts all resident licensees practicing insurance, except for producers licensed to sell only "limited lines insurance," and requires them to periodically complete procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met.

**002. -- 009. (RESERVED)**

**010. DEFINITIONS.**
1. Licensee. An individual holding a license as a producer, bail, adjuster, or public adjuster pursuant to Title 41, Chapters 10, 11, or 58, Idaho Code.

**011. (RESERVED)**

**012. BASIC REQUIREMENTS.**
01. Proof of Completion. As a condition for the continuation of a license, a licensee must complete a total of 24 hours of continuing education credits, including a minimum of 3 ethics credits on or before the licensing renewal date every two (2) years. Proof of satisfactory completion of approved subjects or courses will be downloaded to licensing records by the system vendor in a format acceptable to the Director.
    a. No more than four (4) hours of continuing education credit from courses approved for adjusters or public adjusters can apply toward the continuation of a producer license.
02. Completion Within Two Years. Each course to be applied toward satisfaction of the continuing education requirement is to be completed within the two (2) year period immediately preceding renewal of the license. Courses cannot have been duplicated in the same renewal period. The date of completion for a self-study course is the date of successful completion of exam.

**013. EXCEPTIONS/EXTENSIONS.**
01. Exceptions and Extensions. The following exceptions and extensions may be made to the continuing education rules:
    a. Licensees on extended active duty with the Armed Forces of the United States for the period of such duty and all other exceptions allowed under Section 41-1008(4), Idaho Code.
    b. Persons which hold a temporary license as provided in Section 41-1015, Idaho Code.
    c. The Continuing Education Advisory Committee or the Director may approve an exception or extension for an extra ordinary situation that is requested by a licensee, in writing, setting forth the basis for the exception or extension, and received prior to the renewal date by the Director or Committee.

**014. CONTINUING EDUCATION ADVISORY COMMITTEE.**
01. Continuing Education Advisory Committee. An eleven (11) member Continuing Education Advisory Committee ("Committee") comprised of representatives from each segment of the insurance industry, is appointed by the Director. Committee members will serve a term of three (3) years.
02. Duties of the Committee. The Committee performs the following duties at the discretion of the Director:
    a. Approve or disapprove courses as per the standards of this rule and assign the number of continuing education hours to be awarded.
    b. Consider applications for exceptions and extensions as permitted under Section 013; and
    c. Consider other matters as the Director may assign.
03. Quorum. Those present at any meeting of the Committee are a quorum for purposes of acting to perform the duties of the Committee pursuant to this rule. Matters before the Committee may be decided by a majority of those members present. In the event of a tie vote, the Chairman votes to break the tie.

**015. PROGRAM REQUIREMENTS.**
All continuing education programs need to be submitted to the Committee in accordance with Section 021 on forms promulgated by the Director. Any course provider that resides in and has had their continuing education program(s) approved by, a state in which the insurance department has signed a separate reciprocity agreement with the Idaho Department, need not have their continuing education program(s) reviewed and approved by the Committee. However, all such courses need to be filed with the Department in a format approved by the Director and course application fees paid.

**016. PROGRAMS WHICH QUALIFY.**
01. Requirements of Acceptable Program. A specific program will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each individual licensee to determine the course of study to be pursued. All programs need to meet the standards outlined in Section 018.
02. Subjects Which Qualify.
    a. The following general subjects are acceptable for producers.
        i. Insurance, fixed & indexed annuities, and risk management.
        ii. Insurance laws and rules.
        iii. Mathematics, statistics, and probability.
        iv. Economics.
        v. Business law.
        vi. Finance.
        vii. Taxes, trusts, estate planning.
        viii. Business environment, management, or organization.
        ix. Securities.

b. The following general subjects are acceptable for adjusters and public adjusters.
i. Insurance.
ii. Insurance laws and rules.
iii. Mathematics, statistics, and probability.
iv. Economics.
v. Business law.
vi. Restoration.
vii. Communications.
viii. Arbitration.
ix. Mitigation.
x. Glass replacement and/or repair.

c. Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to professional competence and meet the standards set forth in this rule. The responsibility for substantiating that a particular program meets the requirements of this rule rests solely upon the licensee.

**017. PROGRAMS WHICH DO NOT QUALIFY.**

01. Any Course Used to Prepare for Taking an Insurance Licensing Examination.
02. Committee Service of Professional Organizations.
03. Computer Science Courses.
04. Motivation, Psychology, or Selling Skills Courses.
05. Reviews, Quizzes and/or Examinations.
06. Any Program Not in Accordance with This Rule.

**018. STANDARDS FOR CONTINUING EDUCATION PROGRAMS.**

To qualify for credit, the following standards need to be met by all continuing education programs:

01. Program Development.
a. The program provides significant intellectual or practical content to enhance and improve the insurance knowledge and professional competence of participants.
b. The program is developed by persons who are qualified in the subject matter and instructional design.
c. The program content is current or up to date.
02. Program Presentation.
a. Instructors are qualified, both with respect to program content and teaching methods. Instructors will be considered qualified if, through formal training or experience, they have obtained sufficient knowledge to instruct the course competently.
b. The number of participants and physical facilities is consistent with the teaching method specified.
c. All programs will include some means for evaluating quality.

**019. MEASUREMENT OF CREDIT.**

01. Credits Measured in Full Hours. Professional education courses are credited for continuing education purposes in full hours only. The number of hours is equivalent to the actual number of contact hours which need to include at least fifty (50) minutes of instruction or participation. No credit will be given for partial attendance.
02. Internet Courses. Internet self-study courses will be credited one (1) hour of continuing education for every fifty (50) minutes of study material, excluding exams. Credit will be given in accordance with Section 021.
03. Webinar Courses. Webinars will be credited as classroom instruction or participation. In the event one (1) course encompasses multiple webinars and self-study is necessary between webinars, the self-study material need to be submitted to the Committee to be evaluated for additional credit in accordance with Section 021.

**020. CONTROLS AND REPORTING**.

01. Licensee to Retain Original Certificate as Evidence. The original certificate of completion received for each educational program or course is retained by the licensee to evidence completion during the two (2) year renewal period. The certificate of completion is in a format provided to the Department.
02. Sign-In and Sign-Out Sheets. Sign-in and sign-out sheets are to be used and monitored to ensure attendance for the full length of the seminar. No certificate of completion is to be given to anyone arriving late or leaving prior to the conclusion of the seminar. Failure to comply with these requirements will result in loss of certification of the provider in accordance with Section 023.

**021. APPROVED PROGRAMS OF STUDY - CERTIFICATION BY DIRECTOR.**

01. Requirements of Course Approval. All courses are approved by the Committee. If a course is not approved in advance of presentation, an application for credit may be submitted to the Committee within sixty (60) days of completion of the course.
02. Nonrefundable Application Fee. Each course application is accompanied by a nonrefundable application fee (as set forth in IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges").
03. Course Approval Procedures. Any person intending to provide courses applies in a format prescribed by the Department and provides the following supporting documentation:
a. A specific outline and/or course material;
b. Time schedule;
c. Method of presentation;
d. Qualifications of instructor; and
e. Other information supporting the request for approval.
04. Method to Determine Completion. The submission includes a statement of the method used to determine the satisfactory completion of the course. Methods may be an examination, or certification by the provider of the agent's program attendance or completion, or other methods approved by the Director.
05. Certification of Program. Certification of a program is effective for two (2) years or until any material changes are made in the program, after which it may be resubmitted to the Committee for approval.

**022. PROOF OF COMPLETION.**
An authorized representative of the sponsoring organization will, within thirty (30) days of completion of the course, provide a certificate of completion to each individual who satisfactorily completed the course and certify to the Department electronically a list of all such individuals.

**023. APPROVED SUBJECTS - LOSS OF CERTIFICATION.**
01. Program Suspension. The certification of a program may be suspended by the Director if it has been determined that:
    a. The program teaching method or program content no longer meets the standards of this rule, or have been significantly changed without notice to the Director for recertification;
    b. The program certified to the Director that an individual completed the program, when in fact the individual had not done so;
    c. Individuals who have satisfactorily completed the program of study were not so certified by the program;
    d. The instructor or sponsoring organization is not qualified per the standards of this rule or lacks education or experience in the subject matter of the proposed course;
    e. The instructor, sponsoring organization, or any company or affiliate of a sponsoring organization has had a license revoked or suspended in any jurisdiction. This includes any firm or organization where a revoked or suspended individual has a substantial ownership interest, or other control in a firm or organization; or
    f. There is other good and just cause why certification should be suspended.
02. Reinstatement of a Suspended Certification. Reinstatement of a suspended certification will be made upon proof satisfactory to the Committee or the Director, that the conditions responsible for the suspension have been corrected.

**024. CREDIT FOR INDIVIDUAL STUDY PROGRAMS.**
01. Requirements for Credit of Independent Study Programs. All approved correspondence courses or independent study programs need to include an examination which requires a score of seventy percent (70%) or better to earn a certificate of completion. For each approved course, the sponsoring organization will maintain multiple tests (two (2) or more) sufficient to maintain the integrity of the testing process. A written explanation of test security and administration methods will accompany the course examination materials. Each unit and/or chapter of a course will contain review questions that can be answered with a score of seventy percent (70%) or better before access to the following unit/chapter is allowed.
02. Completed Tests. The examinations are administered, graded, and the results recorded by the organization to which approval was originally granted. Completed tests are retained by the sponsoring organization and will not be returned to any licensee.
03. Prior Approval Needed for Correspondence courses. All correspondence courses need be submitted for approval and approved prior to being offered to licensees for continuing education credit.

**025. CREDIT FOR SERVICE AS LECTURER, DISCUSSION LEADER, OR SPEAKER.**
Only one (l) hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader.