Dear Senators COOK, Lenney, Ward-Engelking, and
Representatives CLOW, Ehlers, Berch:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Insurance:

IDAPA 18.04.04 - The Managed Care Reform Act Rule (ZBR Chapter Rewrite) - Proposed Rule (Docket No. 18-0404-2301);

IDAPA 18.04.08 - Individual and Group Supplementary Disability Insurance Minimum Standards Rule (ZBR Chapter Rewrite) - Proposed Rule (Docket No. 18-0408-2301).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10/19/2023. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 11/16/2023.

The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-4854, or send a written request to the address on the memorandum attached below.

Terri Kondeff
Director

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Commerce & Human Resources Committee and the House Business Committee

FROM: Senior Legislative Drafting Attorney - Jill Randolph

DATE: October 2, 2023

SUBJECT: Department of Insurance

IDAPA 18.04.04 - The Managed Care Reform Act Rule (ZBR Chapter Rewrite) - Proposed Rule (Docket No. 18-0404-2301)

IDAPA 18.04.08 - Individual and Group Supplementary Disability Insurance Minimum Standards Rule (ZBR Chapter Rewrite) - Proposed Rule (Docket No. 18-0408-2301)

Summary and Stated Reasons for the Rule

Docket No. 18-0404-2301: The Department of Insurance notes that this is a Zero-Based Regulation ("ZBR") chapter rewrite pursuant to Executive Order 2020-01. Accordingly, the Department states this rulemaking is intended to streamline and simplify existing rules previously submitted and reviewed by the Legislature regarding the operating procedures of the Managed Care Reform Act.

Docket No. 18-0408-2301: The Department notes that this is a Zero-Based Regulation ("ZBR") chapter rewrite pursuant to Executive Order 2020-01. Accordingly, the agency states this rulemaking is intended to streamline and simplify existing rules previously submitted and reviewed by the Legislature regarding the terms and coverage of individual and group supplemental disability liability.

Negotiated Rulemaking / Fiscal Impact

Negotiated rulemaking was conducted for both dockets. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published for both dockets in the June 7, 2023 edition of the Administrative Bulletin. Neither docket is anticipated to have a negative fiscal impact on the General Fund.

Statutory Authority

This rulemaking appears to be authorized pursuant to Section 41-211, Idaho Code.

cc: Department of Insurance
Weston Trexler

***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.04 – THE MANAGED CARE REFORM ACT RULE

DOCKET NO. 18-0404-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 41, Chapters 2 and 39, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, September 27, 2023
3:00 p.m. to 4:30 p.m. (MT)

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
https://www.microsoft.com/microsoft-teams/join-a-meeting
Meeting ID: 297 636 144 490
Meeting Password: 345BQf
or by phone: +1 208-985-2810,,826046050#

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The purpose of this rule implements the Managed Care Reform Act by defining and establishing operating procedures. This rulemaking is consistent with the Governor's Executive Order 2020-01: Zero-Based Regulation. The proposed changes are to simplify, clarify, and reduce.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2023 Idaho Administrative Bulletin, Vol. 23-06, pages 56-57, under Docket No. 18-ZBRR-2301.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 3rd day of August, 2023.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID, 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 18-0404-2301
(ZBR Chapter Rewrite)

18.04.04 – THE MANAGED CARE REFORM ACT RULE

000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 39, Idaho Code. ~~(3-31-22)~~( )

001. ~~TITLE AND~~ SCOPE.
This rule defines procedures to be followed in establishing and operating a Managed Care Organization. ( )

~~**01. Title**. IDAPA 18.04.04, "The Managed Care Reform Act Rule." (3-31-22)~~

~~**02. Scope**. The Act and this chapter define procedures to be followed in establishing and operating a Managed Care Organization. (3-31-22)~~

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Balance Billing. The practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. ( )

02. MCO. Managed Care Organizations is abbreviated to MCO in this rule. ( )

03. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or authorized to furnish health care services. ( )

011. ~~APPLICATION FOR CERTIFICATE OF AUTHORITY~~CAPITAL SURPLUS AND DEPOSIT REQUIREMENTS.

~~**01. Certificate of Authority**. Any person offering a managed care plan on a predetermined and~~

~~prepaid basis is transacting the business of insurance and needs to be authorized under a Certificate of Authority issued by the Director of Insurance.~~ ~~(3-31-22)~~

~~**02. Application Requirements**. The application for a Certificate of Authority will include the affidavits, statements, and other information as enumerated in Idaho Code, Sections 41-319, 41-3904, 41-3905, and 41-3906. After receiving these completed documents, the Director has the authority to request any supplemental information before final approval or disapproval is given.~~ ~~(3-31-22)~~

~~**03. Capital Surplus and Deposit Requirements**.~~ ~~(3-31-22)~~

~~a~~**01. Amount**. ~~The Director has established t~~The following minimum capital fund ~~requirements~~ apply, as per Section 41-3905(8), Idaho Code~~, based on the number of enrolled members~~:

Enrolled Members	Capital Funds
0-100	$200,000
101-300	$300,000
301-500	$400,000
501-700	$500,000
701-1,000	$1,000,000
1,001-2,000	$1,500,000
2,001-3,000	$2,000,000

~~(3-31-22)~~( )

~~b~~**02. Time**. Within the following time periods after the organization becomes subject to the Act, ~~I~~in no event will the organization's capital funds be less than ~~the following~~:

One year ~~after the organization becomes subject to the Act~~	$1,000,000
Two years ~~after the date the organization becomes subject to the Act~~	$1,500,000
Three years ~~after the date the organization becomes subject to the Act~~	$2,000,000

~~(3-31-22)~~( )

~~e~~**03. Adjustments**. Immediately upon becoming subject to the Act, the MCO's minimum statutory deposit ~~requirements~~ is calculated as fifty percent (50%) of the amount of the organization's ~~C~~capital funds as calculated above ~~up to a maximum of one million dollars ($1,000,000)~~, but not less than two hundred thousand dollars ($200,000). The ~~amount of the~~ minimum deposit so held ~~by the Department~~ is adjusted based on the organization's December 31~~st~~ and June 30~~th~~ financial statement filings each year. In no event will the minimum prescribed statutory deposit ~~amount~~ be reduced. Upon ~~notification by the Department of the necessary~~ filing a financial statement indicating an increase in the deposit amount, the organization will have no more than thirty (30) days to come into compliance with the prescribed amount. Failure to increase the deposit as prescribed ~~will~~ may subject the organization to suspension or revocation of its certificate of authority pursuant to Section 41-326, Idaho Code. ~~(3-31-22)~~( )

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

~~**01. Permission for Solicitation Requisite**. In accordance with Section 41-3904, Idaho Code, a proposed MCO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed managed care services.~~ ~~(3-31-22)~~

~~**02. Solicitation Materials.**~~ Before contacting potential enrollees or subscribers, the proposed MCO will submit ~~its request for permission to the Director~~ in writing for approval, ~~with~~ copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. ~~(3-31-22)~~( )

~~**03. Methods of Solicitation**. Advertising and solicitation materials used by a proposed MCO need to meet the following minimum requirements:~~ ~~(3-31-22)~~

~~**a.** The prospective enrollee will clearly be advised that:~~ ~~(3-31-22)~~

~~i. The proposed MCO is not as yet authorized to offer health care services in this state;~~ ~~(3-31-22)~~

~~ii. Coverage for health care services is not being provided at the time of the solicitation;~~ ~~(3-31-22)~~

~~iii. The solicitation is not a guarantee that any services will be provided at a future date.~~ ~~(3-31-22)~~

~~**b.** The format and content of any material offered will conform with the MCO Act. Such material will contain but not be limited to the following information:~~ ~~(3-31-22)~~

~~i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled;~~ ~~(3-31-22)~~

~~ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility;~~ ~~(3-31-22)~~

~~iii. The predetermined periodic rate of payment for the proposed services;~~ ~~(3-31-22)~~

~~iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions.~~ ~~(3-31-22)~~

~~**c.** No person will solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO.~~ ~~(3-31-22)~~

013. ANNUAL ~~DISCLOSURE, FILING WITH DIRECTOR~~ STATEMENT.
~~The annual disclosure material prescribed to be filed with the Director pursuant to Section 41-3914, Idaho Code, is filed with the reports to the Director on or before March 1 each year~~The MCO will file an annual statement in accordance with Section 41-335, Idaho Code. ~~(3-31-22)~~( )

014. ~~ANNUAL~~ AUDIT REPORT ~~TO THE DIRECTOR~~.
~~In accordance with Sections 41-3910 and 41-335, Idaho Code, every managed care organization will annually on or before the first day of March, file with the Director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise prescribed by the Director, the statement is to be prepared in accordance with the annual statement instructions and the accounting practices and procedures manual adopted by the National Association of Insurance Commissioners (NAIC) and is to be submitted on the NAIC annual convention blank form. The managed care organization~~ The MCO will ~~also~~ file its annual audited financial report described in Section 41-3910, Idaho Code, in accordance with IDAPA 18.07.04, "Annual Audited Financial Reports." It will include the annual disclosure material described in Section 41-3914, Idaho Code, and the grievance report described in Section 41-3918, Idaho Code. ~~(3-31-22)~~( )

015. PERSONNEL AND FACILITIES LISTING.

01. Current Listing. The MCO will ~~at all times~~ always keep a current list of all personnel, providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list is to be made available to the Director upon request. ~~(3-31-22)~~( )

02. Allowable Expense -- No Balance Billing. No MCO provider or other provider accepting a referral from an MCO, who treats or provides services to an individual covered by the MCO, may charge to or collect from any member or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the MCO or by the administrator for the MCO. Nothing in this section prevents the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. ( )

03. Procedures for Basic Care and Referrals. The MCO will provide basic health care to enrollees through an organized system of health care providers. In plans in which referrals to specialty physicians and ancillary services are prescribed, the MCO provider or the MCO will initiate the referrals. The MCO will inform its providers of their responsibility to provide written referrals and any specific procedures that need to be followed in providing referrals, including prohibition of balance billing. ( )

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, will arrange for covered health care services, including referrals to providers within the organized system of health care providers and noncontracting providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters. ( )

05. Out of Network Services. In the case of provider care which is delivered outside of the organized system of health care providers or defined referral system, the MCO will alert those covered under health benefit plans to the fact that providers which are not MCO providers, or have not accepted written referrals, may balance bill the customer for amounts above the MCO's maximum allowance. Consumers should be encouraged to discuss the issue with their providers ( )

016. -- 999. (RESERVED)

IDAPA 18 – DEPARTMENT OF INSURANCE

18.04.08 – INDIVIDUAL AND GROUP SUPPLEMENTARY DISABILITY INSURANCE MINIMUM STANDARDS RULE

DOCKET NO. 18-0408-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 41, Chapters 2 and 42, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, September 27, 2023
3:00 p.m. to 4:30 p.m. (MT)

In-person participation is available at:
Department of Insurance
700 W. State St. 3rd Floor
Boise, ID 83702

Web meeting link:
https://www.microsoft.com/microsoft-teams/join-a-meeting
Meeting ID: 297 636 144 490
Meeting Password: 345BQf
or by phone: +1 208-985-2810,,826046050#

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

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. This rulemaking is consistent with the Governor's Executive Order 2020-01: Zero-Based Regulation. The proposed changes are primarily to simplify, clarify, and reduce. Additional changes update language and broaden the allowable benefit period for disability insurance protection coverage.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2023 Idaho Administrative Bulletin, Vol. 23-06, pages 56-57, under Docket No. 18-ZBRR-2301.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: This rule incorporates by reference the Outlines of Coverage and notices from the April 1999 version of the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act. Copies of the standards and materials can be found at https://content.naic.org/sites/default/files/MO171.pdf. Due to the length of these materials, the Department finds it is more expedient to incorporate the materials by reference.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 3rd day of August, 2023.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID, 83720-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 18-0408-2301
(ZBR Chapter Rewrite)

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."~~ ~~(3-31-22)~~

~~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.~~ ~~(3-31-22)~~

~~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. ~~It~~ ~~(3-31-22)~~

~~a.~~ ~~This chapter~~ applies to dental plans and vision plans only as specified, and it applies~~.~~ ~~(3-31-22)~~

~~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. ~~(3-31-22)~~( )

~~c. This chapter does not apply to: (3-31-22)~~

~~i. Individual policies or contracts issued pursuant to a conversion privilege under a group policy or certificate. (3-31-22)~~

~~ii. Policies issued to employees or members as additions to franchise plans. (3-31-22)~~

~~iii. Medicare supplement policies subject to Title 41, Chapter 44, Idaho Code, Medicare Supplement Insurance Minimum Standards. (3-31-22)~~

~~iv. Long-term care insurance policies subject to Title 41, Chapter 46, Idaho Code, Long Term Care Insurance. (3-31-22)~~

~~v. Civilian Health and Medical Program of the Uniformed Services, Title 10, Chapter 55, of the United States Code, (CHAMPUS) supplement insurance policies. (3-31-22)~~

~~vi. Individual or group major medical expense coverage, including short-term coverage. (3-31-22)~~

002. INCORPORATION BY REFERENCE.

~~**01. Copies.** May be obtained from the Idaho Department of Insurance. (3-31-22)~~

~~**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 available on the NAIC website https://content.naic.org/sites/default/files/MO171.pdf: ~~(3-31-22)~~( )

~~a~~**01. Hospital Confinement Indemnity Coverage**. ( )

~~b~~**02. Disability Income Protection Coverage**. ( )

~~c~~**03. Accident Only Coverage**. ( )

~~d~~**04. Specified Disease**. ( )

~~e~~**05. Specified Accident**. ( )

~~f~~**06. Limited Benefit Health Coverage**. ( )

~~g~~**07. Dental Plans**. ( )

~~h~~**08. Vision Plans**. ( )

~~i~~**09. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (direct sales)**. ( )

~~j~~**10. 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. ( )

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~~ which occurs while the ~~insurance~~ coverage is in force. ~~(3-31-22)~~( )

b. It may exclude injuries for which benefits are provided~~:~~ under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless not allowed by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. ~~(3-31-22)~~( )

~~i. Under workers' compensation, employers' liability, or similar law; or~~ ~~(3-31-22)~~

~~ii. Under a motor vehicle no-fault plan, unless the motor vehicle no-fault plan provides for coordination of benefits; or~~ ~~(3-31-22)~~

~~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.~~ ~~(3-31-22)~~

02. Convalescent Nursing Home. "Convalescent nursing home," "extended care facility," "assisted living facility", or "skilled nursing facility" is to be defined in relation to its status, facility and available services.

~~(3-31-22)~~( )

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 or medicaid benefits, if so requested; ~~(3-31-22)~~( )

iii. ~~Be primarily engaged in providing~~Provide, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; ~~(3-31-22)~~( )

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:~~ exclude a home, facility or part of a home or facility used primarily: for rest, for the aged, for individuals with a substance use disorder or a mental disease or disorder, or for custodial or educational care. ~~(3-31-22)~~( )

~~i. A home, facility or part of a home or facility used primarily for rest;~~ ~~(3-31-22)~~

~~ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or~~ ~~(3-31-22)~~

~~iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.~~ ~~(3-31-22)~~

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~~: ~~(3-31-22)~~( )

a. ~~It i~~Is primarily engaged in providing home health care services; ~~(3-31-22)~~( )

b. ~~Its~~ Has policies ~~are~~ established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse); ~~(3-31-22)~~( )

c. ~~A~~Has a physician or a registered nurse ~~provides supervision of~~ supervising the home health care services; ~~(3-31-22)~~( )

d. ~~It m~~Maintains clinical records on all patients; and ~~(3-31-22)~~( )

e. ~~It h~~Has a full-time administrator. ~~(3-31-22)~~( )

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~~. ~~(3-31-22)~~( )

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~~ may exclude: ~~(3-31-22)~~( )

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 individuals with a substance use disorder; or ~~(3-31-22)~~( )

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~~ means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor. ~~(3-31-22)~~( )

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 word~~s~~ "nurse," ~~"trained nurse" or "registered nurse" are~~ is 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~~. ~~(3-31-22)~~( )

08. One Period of Confinement. "One (1) period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three (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~~:~~ ~~(3-31-22)~~

~~**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;~~ ~~(3-31-22)~~

~~**b.** A~~ a condition for which medical advice~~, diagnosis, care~~ or treatment was recommended ~~or received~~ by a provider during the six (6) months immediately preceding the effective date of coverage~~; or~~ ~~(3-31-22)~~

~~**c.** A pregnancy existing on the effective date of coverage~~. ~~(3-31-22)~~( )

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. (3-31-22)~~

~~**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. (3-31-22)~~

03~~**2**~~**. 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~~ A policy may return ~~of~~ unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds. ~~(3-31-22)~~( )

0~~4~~3. 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~~; ~~(3-31-22)~~( )

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 ~~(3-31-22)~~( )

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.~~ ~~(3-31-22)~~

~~**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;~~ ~~(3-31-22)~~

~~**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;~~ ~~(3-31-22)~~

~~**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;~~ ~~(3-31-22)~~

~~**q.** The reversal of an elective sterilization procedure, including but not limited to vasovasostomies or salpingoplastics.~~ ~~(3-31-22)~~

054. 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 hospital confinement indemnity and accident only policies ~~other than disability income or specified disease~~, a ~~n 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. ~~(3-31-22)~~( )

021. -- 029. (RESERVED)

030. MINIMUM STANDARDS FOR BENEFITS.

01. Minimum Standards. ~~The following~~An insurance policy or certificate subject to this chapter will meet the applicable minimum standards ~~for benefits are prescribed for the categories of coverage~~ noted in Sections ~~035~~030 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.~~ ~~(3-31-22)~~( )

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. ~~(3-31-22)~~( )

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.~~ ~~(3-31-22)~~( )

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~~Unfair Exclusions. A policy providing coverage for~~ fractures or dislocations will not~~ certain illnesses and injuries will not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions, such as provide~~e~~ing benefits only for "full or complete" fractures or dislocations. ~~(3-31-22)~~( )

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. (3-31-22)~~

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

~~**c**~~**b.** 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 state 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." ~~(3-31-22)~~( )

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~~ state 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." ~~(3-31-22)~~( )

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~~ for disability income protection coverage are: ~~(3-31-22)~~( )

a. Provides that any 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)~~ are not reduced based on age, except when such reductions do not exceed fifty percent (50%) and do not take place until the individual has reached full retirement age for Social Security benefits; ~~(3-31-22)~~( )

b. Contains an elimination period no greater than~~:~~ one-fourth (1/4) of the maximum payable benefit period, and not exceeding one (1) year; ~~(3-31-22)~~( )

~~i. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less; (3-31-22)~~

~~ii. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years; or (3-31-22)~~

~~iii. Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury; (3-31-22)~~

c. Has a maximum payable benefit period ~~of time for which it is payable during disability~~ of at least ~~six (6)~~ three (3) months. No reduction in benefits is put into effect because of an increase in Social Security or similar benefits during a benefit period. ~~(3-31-22)~~( )

02. Banned **Policy Provisions**. ( )

a. Where a policy provides total disability ~~benefits~~ and partial disability benefits, only one (1) elimination period may ~~be applied~~ applied. ~~(3-31-22)~~( )

~~**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. (3-31-22)~~

~~**c**~~**b.** Disability income protection 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. ~~(3-31-22)~~( )

~~**d**~~**c.** No reduction in benefits will be put into effect because of an increase in Social Security or similar benefits during a benefit period. ( )

~~**e**~~**d.** 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 state 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." ~~(3-31-22)~~( )

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~~ prominently state~~ment~~ on the first page ~~of the policy or certificate~~, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections ~~in the policy or certificate, a prominent statement as follows~~: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ~~(3-31-22)~~( )

b. An accident-only policy or certificate providing benefits that vary according to the type of accidental cause will prominently ~~set forth~~ state 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. ~~(3-31-22)~~( )

c. Accident-only policies or certificates that provide coverage for hospital or medical care will ~~contain the following statement~~ state 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." ~~(3-31-22)~~( )

038. SPECIFIED DISEASE COVERAGE.

01. Minimum Standards for Benefits. The ~~following~~ minimum standards ~~apply to~~ for specified disease coverage are: ~~(3-31-22)~~( )

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.)~~; ~~(3-31-22)~~( )

iv. ~~X-ray, radium and other therapy procedures~~Medical services and supplies used in diagnosis and treatment; ~~(3-31-22)~~( )

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~~Durable medical equipment deemed necessary by the attending

physician for the treatment of the disease; ~~(3-31-22)~~( )

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. ~~(3-31-22)~~( )

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~~Medical services and supplies used in diagnosis and treatment; ~~(3-31-22)~~( )

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~~Durable medical equipment deemed necessary by the attending physician for the treatment of the disease; ~~(3-31-22)~~( )

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:~~ ~~(3-31-22)~~

~~(1) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;~~ ~~(3-31-22)~~

~~(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;~~ ~~(3-31-22)~~

~~(3) Physical, occupational, or speech and hearing therapy;~~ ~~(3-31-22)~~

~~(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;~~ ~~(3-31-22)~~

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." ~~(3-31-22)~~( )

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~~ state~~ment~~ 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. ~~(3-31-22)~~( )

b. All specified disease policies and certificates will ~~contain~~ prominently state 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." ~~(3-31-22)~~( )

c. Outlines of coverage delivered in connection with "Specified Disease" to persons eligible for Medicare by reason of age will ~~contain the following language~~ state 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." ~~(3-31-22)~~( )

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~~Medicare Supplement Insurance Standards." ~~(3-31-22)~~( )

039. SPECIFIED ACCIDENT COVERAGE.

01. Minimum Standards for Benefits. The ~~following~~ minimum standards ~~apply to~~ for specified accident coverage are: ~~(3-31-22)~~( )

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~~ prominently state~~ment~~ 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." ~~(3-31-22)~~( )

b. All specified accident policies and certificates will ~~contain a~~ prominent~~ly~~ state~~ment~~ on the first page ~~of the policy or certificate~~, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections ~~in the policy or certificate, a prominent statement as follows~~: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ~~(3-31-22)~~( )

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 state 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." ~~(3-31-22)~~( )

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;~~ ~~(3-31-22)~~( )

a. All dental coverage applications will ~~contain a~~ prominently state~~ment~~ in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections ~~of the application~~ and in close conjunction with the applicant's signature block ~~on the application as follows~~: "The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate) carefully." ~~(3-31-22)~~( )

b. All dental ~~plan~~ coverage policies and certificates will ~~display~~ prominently state 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." ~~(3-31-22)~~( )

042. VISION COVERAGE.

01. Disclosure Provisions. ~~Vision coverage will include the following disclosures;~~ ~~(3-31-22)~~( )

a. All vision coverage applications will ~~contain a~~ prominently state~~ment~~ in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections ~~of the application~~ and in close conjunction with the applicant's signature block ~~on the application as follows~~: "The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully." ~~(3-31-22)~~( )

b. All vision ~~plan~~ coverage policies and certificates will ~~display~~ prominently state 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." ~~(3-31-22)~~( )

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~~ prominently state~~ment~~ in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections ~~of the application~~ and in close conjunction with the applicant's signature block ~~on the application as follows~~: "The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully." ~~(3-31-22)~~( )

b. The first page of ~~E~~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. ~~(3-31-22)~~( )

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~~ state 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. ~~(3-31-22)~~( )

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~~ stated in the outline of coverage. ~~(3-31-22)~~( )

i. If a policy or certificate contains a conversion privilege, it will~~ comply, in substance,~~ substantively comply with~~ the following~~: ~~(3-31-22)~~( )

i. The provision's caption~~ of the provision~~ will be "Conversion Privilege"~~ or words of similar import~~. ~~(3-31-22)~~( )

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.~~ ~~(3-31-22)~~( )

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 delivered policy or certificate ~~when it is delivered~~ and ~~contain the following~~ will state~~ment~~ 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."**
~~(3-31-22)~~( )

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.~~
~~(3-31-22)~~( )

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.
( )

202. -- 999. (RESERVED)