TITLE 41
INSURANCE

CHAPTER 22
GROUP AND BLANKET DISABILITY INSURANCE

41-2201. SCOPE OF CHAPTER -- SHORT TITLE. (1) This chapter applies only to group disability insurance contracts and to blanket disability insurance contracts as herein provided for.

(2) This chapter may be cited as the "group or blanket disability insurance law".

[41-2201, added 1961, ch. 330, sec. 527, p. 645.]

41-2202. "GROUP DISABILITY INSURANCE" DEFINED -- ELIGIBLE GROUPS. "Group disability insurance" is hereby declared to be that form of disability insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term "employees" as used herein may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(2) Under a policy issued to an association, including a labor union, which shall have a constitution and by-laws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used herein may include retired employees.

(3) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subdivision (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or of such association, or employees of members of such association, for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used herein may include retired employees. The policy may provide that the term "employees" shall include the trustees or their

employees, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy.

(5) Under a policy issued to cover any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group disability policy or contract.

(6) Any group disability policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

[41-2202, added 1961, ch. 330, sec. 528, p. 645.]

41-2203. REQUIRED PROVISIONS IN GROUP POLICIES. Each such group disability insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

(2) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one (1) certificate need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) A provision that, 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 a member of an insured group 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 member for support and maintenance, not so terminate while the policy remains in force and the dependent remains in such condition, if the member 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.

[41-2203, added 1961, ch. 330, sec. 529, p. 645; am. 1972, ch. 348, sec. 3, p. 1030; am. 2010, ch. 235, sec. 33, p. 569.]

41-2204. DIRECT PAYMENT OF HOSPITAL AND MEDICAL SERVICES. Any group disability policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

[41-2204, added 1961, ch. 330, sec. 530, p. 645.]

41-2205. READJUSTMENT OF PREMIUMS -- DIVIDENDS. Any contract of group disability insurance may provide for the readjustment of the rate of premium based upon the experience thereunder. If a policy dividend is hereafter declared or a reduction in rate is hereafter made or continued for the first or any subsequent year of insurance under any policy of group disability insurance heretofore or hereafter issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under such policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer or insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of such policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

[41-2205, added 1961, ch. 330, sec. 531, p. 645.]

41-2206. "BLANKET DISABILITY INSURANCE" DEFINED. "Blanket disability insurance" is hereby declared to be that form of disability insurance covering groups of persons as enumerated in one of the following subdivisions.

(1) Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on such common carrier or such means of transportation.

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering the employer and all employees, dependents or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents or guests similarly defined.

(3) Under a policy or contract issued to a school, or other institution of learning, camp or sponsor thereof; or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employees may be included.

(4) Under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization.

(5) Under a policy or contract issued to a sports team or sponsors thereof which shall be deemed the policyholder, covering members, officials and supervisors.

(6) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group.

(7) Under a policy or contract issued to cover any other risk or class of risks which, in the discretion of the director may be properly eligible for blanket disability insurance. The discretion of the director may be exercised on an individual risk basis or class of risks, or both.

[41-2206, added 1961, ch. 330, sec. 532, p. 645.]

41-2207. REQUIRED PROVISIONS IN BLANKET POLICIES. Any insurer authorized to write disability insurance in this state shall have the power to issue blanket disability insurance. No such blanket policy may be issued or delivered in this state unless a copy of the form thereof shall have been filed in accordance with section 41-1812. Every such blanket policy shall contain provisions which in the opinion of the director are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within thirty (30) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable, and that any bal-

ance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make any autopsy in case of death where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

[41-2207, added 1961, ch. 330, sec. 533, p. 645.]

41-2208. APPLICATION AND CERTIFICATES NOT REQUIRED. An individual application shall not be required from a person covered under a blanket disability policy or contract, nor shall it be necessary for the insurer to furnish each such person a certificate of the insurance.

[41-2208, added 1961, ch. 330, sec. 534, p. 645.]

41-2209. PAYMENT OF BENEFITS UNDER BLANKET POLICY. All benefits under any blanket disability policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate; except, that if the person insured be a minor or mental incompetent, such benefits may be made payable to his parent, guardian, or other person actually supporting him; or if the entire cost of the insurance has been borne by the employer such benefits may be made payable to the employer. Provided, however, that the policy may provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

[41-2209, added 1961, ch. 330, sec. 535, p. 645.]

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.

(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.

[41-2210, as added by 1974, ch. 66, sec. 3, p. 1146; am. 1976, ch. 113, sec. 2, p. 444; am. 1993, ch. 305, sec. 2, p. 1130; am. 1994, ch. 365, sec. 4, p. 1151; am. 1997, ch. 321, sec. 2, p. 950; am. 2008, ch. 296, sec. 1, p. 825; am. 2009, ch. 125, sec. 2, p. 392.]

41-2210A. LIMITATION OF BENEFITS FOR ELECTIVE ABORTIONS. All policies, contracts, plans or certificates of group or blanket disability insurance delivered, issued for delivery or renewed in this state after the effective date of this section shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the insurance carrier. For purposes of this section, an "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

[41-2210A, added 1983, ch. 94, sec. 2, p. 207.]

41-2210D. CONVERSION PLAN -- WHEN REQUIRED. Any group carrier doing business in the state of Idaho that does not have an individual product on file with the department of insurance shall provide a conversion plan to all group insureds. The conversion plan shall provide benefits at least equal to the standard health benefit plan developed pursuant to section 41-4712, Idaho Code. The premium under the plan shall not exceed one hundred twenty-five percent (125%) of the index rate for groups.

[41-2201D, added 1996, ch. 124, sec. 1, p. 438.]

41-2211. SCOPE OF ACT -- REPLACEMENT OF GROUP DISABILITY INSURANCE, GROUP NONPROFIT HOSPITAL AND MEDICAL SERVICE CONTRACTS AND HEALTH CARE SERVICE PLANS. The provisions of this act shall apply to all policies of group disability insurance issued in this state pursuant to the provisions of chapter 22, title 41, Idaho Code, and any group nonprofit hospital and medical service contract issued in this state pursuant to the provisions of chapter 34, title 41, Idaho Code, and all group health care service plans issued in this state pursuant to chapter 39, title 41, Idaho Code.

[41-2211, added 1975, ch. 204, sec. 2, p. 565.]

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.

[41-2212, added 1975, ch. 204, sec. 3, p. 565.]

41-2213. POLICY STANDARDS -- DISABLED INDIVIDUALS. Every policy containing the benefits described in subsections (1), (2) and (3) of this section must contain a provision which provides for a reasonable extension of benefits with respect to employees or dependents who become totally disabled after the effective date of this act and continue to be totally disabled at the date of discontinuance of the policy. Such an extension of benefits provision will be deemed a reasonable extension of benefits provision if it complies with the standards set forth in subsections (1), (2) and (3) of this section.

(1) In the case of a policy providing benefits for loss of time or a specific indemnity during hospital confinement, the extension of benefits provision will be deemed reasonable if continuance does not affect the benefit provided.

(2) In the case of a policy providing hospital, medical or surgical expense coverage, the extension of benefits provision will be deemed reasonable if it provides benefits for covered expenses incurred as the result of the disabling condition beyond the date of discontinuance for a period of not less than twelve (12) months.

(3) In the case of a policy providing loss by dismemberment, the extension of benefits provision will be deemed reasonable if it provides benefits for dismemberment loss that occurs after termination of policy that was a result of a disabling condition that occurred while the policy was in effect. Benefits for any such loss will be payable under the policy, in accordance

with its limitations, exceptions and provisions as if this policy had not been so terminated.

The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy. Any extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled.

[41-2213, added 1975, ch. 204, sec. 4, p. 565; am. 1978, ch. 8, sec. 1, p. 14.]

41-2214. POLICY STANDARDS -- MATERNITY BENEFITS. If a policy provides any benefits for pregnancy, childbirth or miscarriage and if an employee or dependent covered for such benefit is pregnant at the time of discontinuance and is not eligible for any replacement group coverage within sixty (60) days of discontinuance, the policy must provide that benefits will be payable to the same extent as if discontinuance had not occurred for any covered benefits in connection with such pregnancy, childbirth or miscarriage, but not beyond a period of twelve (12) months following such discontinuance.

[41-2214, added 1975, ch. 204, sec. 5, p. 565; am. 2001, ch. 129, sec. 1, p. 451.]

41-2215. POLICY STANDARDS -- REPLACEMENT CONTRACTS. (1) Any carrier providing replacement coverage with respect to hospital, medical or surgical expense benefits within a period of sixty (60) days from the date of discontinuance of a prior policy providing such hospital, medical or surgical expense benefits shall immediately cover all employees and dependents validly covered under the previous policy at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding carrier's policy, regardless of any limitations or exclusions relating to active employment or nonconfinement.

(2) With respect to an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's policy and required to be covered under subsection (1) of this section, the succeeding carrier shall be entitled to deduct from any benefits becoming payable under its policy the amount of benefits payable by the prior carrier pursuant to an extension of benefits provision.

(3) An employee or dependent entitled to coverage under a succeeding carrier's policy pursuant to subsection (1) or (2) of this section shall continue to be covered by the succeeding carrier until the earlier of the following:

(a) The date coverage would terminate for an employee or dependent in accordance with the provisions of the succeeding carrier's policy; or

(b) In the case of an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's policy and entitled to an extension of benefits pursuant to subsection (2) of section 41-2213, the date the period of extension of benefits terminates or, if the prior carrier's policy is not subject to this act, the date to which benefits would have been extended had the prior carrier's policy been subject to this act.

(4) No provision in a succeeding carrier's policy of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's policy shall be applied with respect to those employees

and dependents validly insured under the prior carrier's policy on the date of discontinuance, if benefits for such condition would have been payable under the prior carrier's policy.

(5) In a situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding carrier, at no cost.

[41-2215, added 1975, ch. 204, sec. 6, p. 565; am. 2003, ch. 307, sec. 1, p. 843.]

41-2216. COORDINATION OF BENEFITS -- COORDINATION WITH SOCIAL SECURITY BENEFITS. (1) Under the authority of this section and section 41-2141, Idaho Code, the director shall promulgate rules that are in accordance with the model regulations of the national association of insurance commissioners relating to coordination of benefits provisions in group and individual disability insurance policies. This section shall apply to all policies of group disability insurance or coverage issued in this state pursuant to the provisions of chapters 22, 34, 39 and 47, title 41, Idaho Code. These rules shall establish uniformity in the permissive use of provisions governing the coordination of benefits between group disability policies and between group disability policies and individual disability policies in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions.

(2) Any provision contained in a policy of group or blanket disability insurance providing for a reduction of benefits payable under the policy during a policy benefit period due to an increase in benefits payable under the federal social security act, as amended, shall be null and void with respect to any such increase which occurs on or after the effective date of this act.

[41-2216, added 1978, ch. 10, sec. 2, p. 20; am. 1989, ch. 143, sec. 1, p. 348; am. 1997, ch. 319, sec. 2, p. 943.]

41-2217. SERVICES PROVIDED BY GOVERNMENTAL ENTITIES. (1) From and after July 1, 1990, no group or blanket disability insurance policy shall be issued in Idaho which excludes from coverage services rendered the insured while a resident in an Idaho state institution, provided the services to the insured would be covered by the policy if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no group or blanket disability insurance policy may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a policy which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of insurance coverage.

[41-2217, added 1990, ch. 300, sec. 2, p. 828.]

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.

[41-2218, added 1992, ch. 132, sec. 2, p. 414; am. 1993, ch. 113, sec. 2, p. 289.]

41-2220. COVERAGE PROVIDED TO PERSONS HAVING INSURANCE. [(1)] An insurer providing group disability insurance coverage in this state shall make available to citizens of this state current major medical disability benefit policies under the terms set forth in this section. An insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation, or automobile medical payment insurance is not required to comply with the provisions of this section. An insurer providing only specified disease or hospital confinement indemnity insurance in this state shall not be required to comply with the provisions of this section, provided the insurance is marketed as supplemental health insurance and not as a substitute for hospital or major medical expense insurance, and the insurer certifies annually to the director that the insurance is being marketed in a manner consistent with the provisions of this subsection.

(2) As used in this section, the term "major medical disability policies" means policies, including medicare supplement insurance policies, contracts or certificates which are issued to provide hospital and medical-surgical coverage.

(3) Each insurer offering or maintaining group major medical disability policies in this state shall make a current group or individual policy available to an individual or dependent of an individual currently under group coverage by the insurer following expiration or the insured's declination of COBRA benefit coverage, if applicable, or otherwise upon termination of group coverage, without imposition by the insurer of underwriting criteria whereby coverage of an individual or a dependent of an individual is denied or subject to cancellation or nonrenewal, in whole or in part because of the individual's age, health or medical history or employment status, or, if employed, industry or job classification if the individual is insured with that insurer and wishes to convert coverage to

another policy, plan or contract. When offering benefits pursuant to this section, the insurer shall be required to offer equal or lesser benefits than the insured has under the existing policy with the company. If the insurer offers benefits in excess of what was included in the insurer's contract to the insured, the insurer may impose health underwriting criteria and a preexisting condition clause which will waive all or a portion of benefits offered for the first twelve (12) months of the policy for a condition which has occurred during the preceding twelve (12) months. The preexisting condition clause herein authorized may not be applied to the transfer from one (1) medicare supplement policy, contract or certificate to another where benefits are increased. As used herein, "benefits in excess of what was included in the insured's contract" shall include but not be limited to lower deductibles, lower coinsurance or copayments, or lower maximum out-of-pocket expenditure for health care. The addition of pharmacy cards to replace existing prescription drug benefits, supplemental accident insurance, chiropractic services or vision services shall not constitute "benefits in excess of what was included in the insured's contract."

In implementing the provisions of this section, the director shall provide that insurers shall provide insureds with a simplified application that shall not exceed one (1) page in length and which shall not exceed six (6) medical questions.

[(41-2220) 1994, ch. 404, sec. 2, p. 1153; am. and redesig. 1995, ch. 254, sec. 2, p. 833.]

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.

(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.

[41-2221, added 1996, ch. 145, sec. 1, p. 476; am. 1997, ch. 321, sec. 3, p. 952.]

41-2223. RENEWABILITY OF COVERAGE. (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the employer, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or intentional misrepresentation of material fact by the employer;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) In the case of health benefit plans that are made available in the employer market only through one (1) or more associations, as defined in section 41-2202, Idaho Code, the membership of an employer 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;

(f) The employer no longer meets the requirements of section 41-2221(2)(b), Idaho Code;

(g) The carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to large employers 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 twenty percent (20%) of its total number of employees and dependents in all lines of business 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 employers and employees or dependents 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 employers;

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

(iv) In exercising the option to discontinue the health benefit plan and in offering the option to purchase all other health benefit plans under the provisions of this paragraph, act uniformly without regard to:

1. The claims experience of an affected employer;

2. Any health status-related factor relating to any affected employee or dependent; or

3. Any health status-related factor relating to any new employee or dependent who may become eligible for the coverage.

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

(i) Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and

(ii) Provide notice of the decision not to renew coverage to all affected employers 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 employers; or

(i) 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 employers in finding replacement coverage.

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

(3) In the case of a carrier doing business in one (1) established geographic service area of the state, the provisions set forth in this section shall apply only to the carrier's operations in that service area.

[41-2223, added 1997, ch. 321, sec. 4, p. 954; am. 2006, ch. 353, sec. 1, p. 1079.]