

Idaho

INDIVIDUAL
BASIC
HEALTH POLICY

(SAMPLE)



PLEASE READ THIS POLICY CAREFULLY

THE DEFINITIONS AND GENERAL EXCLUSIONS AND LIMITATIONS
ARE VERY IMPORTANT PARTS OF YOUR POLICY

ALL DEFINED WORDS ARE CAPITALIZED WITHIN THE CONTENTS OF THIS POLICY
REFER TO THE DEFINITIONS SECTION FOR CLARIFICATION

Idaho

INDIVIDUAL **STANDARD** **HEALTH POLICY**

(SAMPLE)



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Idaho

INDIVIDUAL **CATASTROPHIC 'A'** **HEALTH POLICY**

(SAMPLE)



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Idaho

INDIVIDUAL **CATASTROPHIC 'B'** **HEALTH POLICY**

(SAMPLE)



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Idaho

HSA COMPATIBLE **HEALTH POLICY**

(SAMPLE)



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DEFINITIONS

1. **"Allowable Expense"** means the Expense incurred for a covered service or supply as determined by either the contractual allowance for participating providers OR the maximum allowance as determined by a carrier's contracted methodologies for non-participating providers.
2. **"Benefit Percentage"** is the percentage of the cost of a health care service, paid by the Insurer under a health insurance plan, as defined in the Schedule of Benefits.
3. **"Calendar Year"** is a period of one year, which starts on January 1 and ends on December 31.
4. **"Coinsurance"** is a percentage of the cost of a health care service, paid by the Insured under a health insurance plan, as defined in the Schedule of Benefits.
5. **"Copayment"** is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a Copayment will be required are specified in the Schedule of Benefits. The Copayment must be paid before any other payment will be made under the policy. The Copayments will not count toward any Deductible or Out-of-Pocket Expense required under the policy, with the exception of the HSA Compatible Plan, where the Copayment will count toward the Out-of-Pocket Expense Maximum.
6. **"Deductible"** means the amount of the covered charge each Insured is obligated to pay each Calendar Year before the plan will pay for covered medical services. All covered charges are subject to the Deductible amount unless specifically noted otherwise.
7. **"Dependent"** means a spouse, an unmarried child under the age of twenty-one (21) years, an unmarried child who is a full time student under the age of twenty-five (25) years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
8. **"Eligible Expense" (Expense)** means the Expense incurred for a covered service or supply. A physician or other licensed facility or Provider has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge:
 - a. For a service or supply which is not Medically Necessary; or
 - b. Which is in excess of reasonable and customary charges for a service or supply; or
 - c. Which is in excess of any contractual arrangements; or
 - d. For a service or supply for which an Insured would have no legal obligation to pay in the absence of coverage under this policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.

9. **“Eligible Individual” (Insured or Individual)** means an Idaho resident Individual or Dependent of an Idaho resident who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (Medicare), or a state plan under title XIX (Medicaid) or any successor program, and who does not have other health insurance coverage. Coverage under a Basic, Standard, Catastrophic A, Catastrophic B, or HSA Compatible Health Benefit Plan shall not be available to any Individual who is covered under other health insurance coverage. Based upon the provisions of section 41-5510, Idaho Code, no coverage is available for any person who voluntarily terminates coverage (unless twelve (12) months have elapsed since the coverage terminated); provided however, that this provision shall not apply with respect to an applicant who is a federally defined Eligible Individual. For purposes of this Policy, additional individual “eligibility requirements” are defined within section 41-5510, Idaho Code.

10. **“Emergency Services”** means those health care services that are provided in a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

- a. Placing the Insured’s health in serious jeopardy;
- b. Serious impairment to bodily functions; or
- c. Serious dysfunction of any bodily organ or part.

11. **“Established Geographic Service Area”** means a geographic area, as approved by the director and based on the Carrier’s certificate of authority to transact insurance in this state within which the Carrier is authorized to provide coverage.

12. **“Health Benefit Plan”** means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident only, credit, dental, vision, Medicare supplement, long-term care, disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

13. **“Individual Carrier” (Carrier or Insurer)** means a Carrier that offers Health Benefit Plans covering Eligible Individuals and their Dependents.

14. **“Medically Necessary”** means a service or supply which is ordered by a Provider and which the Carrier’s medical staff or qualified party or entity determines is:

- a. Provided for the diagnosis or direct treatment of an injury or sickness; or
- b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment for the Insured person’s injury or sickness; or
- c. Not considered experimental or investigative; or

- d. Provided in accordance with generally accepted medical practice; or
- e. The most appropriate supply or level of service which can be provided on a cost effective basis (including but not limited to, in-patient vs. out-patient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

The fact that the Insured's Provider prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the policy.

15. **“Out-of-Pocket Expense Maximum”**. Out-of-pocket expense maximum is the maximum medical expense that an insured is obligated to pay, which includes coinsurance as defined in the Schedule of Benefits. Under the Basic, Standard, and Catastrophic A and B Health Benefit Plans, the out-of-pocket expense maximum does not include Deductibles, Copayments, pharmacy expenses, expenses for non-covered services and supplies, and charges in excess of the Eligible Expense. After the out-of-pocket expense maximum has been reached, covered services will be provided at one hundred percent (100%) except for specific Deductibles, Copayments, pharmacy benefits, non-covered services and supplies, and charges in excess of the Eligible Expense. The HSA Compatible Plan Calendar Year out-of-pocket expense maximum, subject to any policy limitations or ineligible out-of-pocket expenses, includes Deductibles, Copayments, and Coinsurance including pharmacy expenses. After the HSA Compatible Plan out-of-pocket expense maximum has been reached, covered services will be provided at one hundred percent (100%) with the exception of services, supplies, and charges in excess of the Eligible Expense.

16. **“Pre-Existing Condition”** means a Health Benefit Plan shall not deny, exclude or limit benefits for a covered Individual for covered Expenses incurred more than twelve (12) months following the effective date of the Individual's coverage due to a Pre-Existing Condition.

- a. A Health Benefit Plan shall not define a Pre-Existing Condition more restrictively than:
 - i. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;
 - ii. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or
 - iii. A pregnancy existing on the effective date of coverage.
- b. A Health Benefit Plan shall waive any time period applicable to a Pre-Existing Condition exclusion or limitation period with respect to particular services for the period of time an Individual was previously covered by Qualifying Previous Coverage to the extent such previous coverage provided benefits with respect to such services, provided that the Qualifying Previous Coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage.

- c. An Individual Carrier shall not modify a Basic, Standard, Catastrophic A, Catastrophic B, or HSA Compatible Health Benefit Plan with respect to an Individual or any Dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the Health Benefit Plan.
17. **“Premium”** means all moneys paid by an Individual and eligible Dependents as a condition of receiving coverage from a Carrier, including any fees or other contributions associated with the Health Benefit Plan.
18. **“Provider”** means any of the following licensees duly licensed to practice in any of the following categories of health care professions:
- a. Licensed General Hospital;
 - b. Chiropractor;
 - c. Dentist;
 - d. Optometrist;
 - e. Pharmacist;
 - f. Physician and Surgeon, of either medicine and surgery, or of osteopathic medicine and surgery;
 - g. Podiatrist; and
 - h. Any other licensed facility or practitioner who is acting within the scope of that license and who performs a service which is payable under the policy when performed by any of the above health care Providers. A Provider does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).
19. **“Qualifying Previous Coverage”** and **“Qualifying Existing Coverage”** means benefits or coverage provided under:
- a. Medicare or Medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian Health Service Program, a state health benefit risk pool, or any other similar publicly sponsored program; or
 - b. Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society.
20. **“Restricted Network Provision”** means any provision of a Health Benefit Plan that conditions the payment of benefits, in whole or in part, on the use of health care Providers that have entered into contractual arrangements with the Carrier to provide health care services to covered Individuals.

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BASIC BENEFIT PLAN
Schedule of Benefits

All Benefit Areas - Lifetime Benefit Maximum per Carrier	\$500,000
Preventive Services - Benefit Area “A” (Calendar Year Benefit Maximum) Subject to Deductible and Coinsurance Mammography benefits are not limited to the preventive services benefit	\$200
 Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	\$500
Benefit Percentage	50%
Coinsurance Percentage	50%
Individual Out-of-Pocket Expense Maximum not including Deductible or Copayments	\$20,000
Normal Maternity Benefit Deductible - Benefit Area “B” Not applicable to involuntary complications of pregnancy	\$5,000
Organ Transplant - Benefit Area “C” Lifetime Maximum Benefit	\$250,000
Skilled Nursing Facility - Benefit Area “C” Calendar Year Benefit Maximum	45 days
Rehabilitation Therapy - Benefit Area “C” Calendar Year Inpatient Benefit Maximum	\$25,000
Rehabilitation Therapy - Benefit Area “D” Combined Calendar Year Outpatient Benefit Maximum	\$2,000
Home Health Care Benefits - Benefit Area “D” Calendar Year Benefit Maximum	\$5,000
Hospice Care - Benefit Area “D” Calendar Year Benefit Maximum	\$5,000
Ambulance Service - Benefit Area “E” Calendar Year Benefit Maximum	\$2,000
Durable Medical Equipment - Benefit Area “E” Calendar Year Benefit Maximum	\$10,000

BASIC BENEFIT PLAN (continued)
Schedule of Benefits (continued)

Psychiatric and Substance Abuse Services - Benefit Area “F”	
Covered benefit as an inpatient or outpatient combined	
Calendar Year Benefit Maximum	\$5,000
Pharmacy - Benefit Area “G”	
Calendar Year Pharmaceutical Deductible - Individual	\$250
Benefit Percentage	50%
Coinsurance Percentage	50%
Does not apply to Out-of-Pocket Expense limit	
Benefits are limited to a thirty (30) day supply	

STANDARD BENEFIT PLAN
Schedule of Benefits

All Benefit Areas - Lifetime Benefit Maximum per Carrier	\$1, 000,000
Preventive Services - Benefit Area “A”	
Calendar Year Benefit Maximum	\$200
Subject to Deductible and Coinsurance	
Mammography benefits are not limited to the preventive services benefit	
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	\$1,000
Benefit Percentage	70%
Coinsurance Percentage	30%
Individual Out-of-Pocket Expense Maximum not including Deductible or Copayments	\$10,000
Normal Maternity Benefit Deductible - Benefit Area “B”	\$5,000
Not applicable to involuntary complications of pregnancy	
Organ Transplant - Benefit Area “C”	
Lifetime Maximum Benefit	\$250,000
Skilled Nursing Facility - Benefit Area “C”	
Calendar Year Benefit Maximum	45 days
Rehabilitation Therapy - Benefit Area “C”	
Calendar Year Inpatient Benefit Maximum	\$25,000
Rehabilitation Therapy - Benefit Area “D”	
Combined Calendar Year Outpatient Benefit Maximum	\$2,000
Home Health Care Benefits - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Hospice Care - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Ambulance Service - Benefit Area “E”	
Calendar Year Benefit Maximum	\$2,000
Durable Medical Equipment - Benefit Area “E”	
Calendar Year Benefit Maximum	\$10,000

STANDARD BENEFIT PLAN (continued)
Schedule of Benefits (continued)

Psychiatric and Substance Abuse Services - Benefit Area “F”	
Covered benefit as an inpatient or outpatient combined	
Calendar Year Benefit Maximum	\$5,000
Pharmacy - Benefit Area “G”	
Calendar Year Pharmaceutical Deductible - Individual	\$250
Benefit Percentage	50%
Coinsurance Percentage	50%
Does not apply to Out-of-Pocket Expense limit	
Benefits are limited to a thirty (30) day supply	

CATASTROPHIC “A” BENEFIT PLAN
Schedule of Benefits

All Benefit Areas - Lifetime Benefit Maximum per Carrier	\$1,000,000
Preventive Services - Benefit Area “A”	
Calendar Year Benefit Maximum	\$200
Subject to Deductible and Coinsurance	
Mammography benefits are not limited to the preventive services benefit	
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	\$2,000
Benefit Percentage	70%
Coinsurance Percentage	30%
Individual Out-of-Pocket Expense Maximum not including Deductible or Copayments	\$10,000
Normal Maternity Benefit Deductible - Benefit Area “B”	\$5,000
Not applicable to involuntary complications of pregnancy	
Organ Transplant - Benefit Area “C”	
Lifetime Maximum Benefit	\$250,000
Skilled Nursing Facility - Benefit Area “C”	
Calendar Year Benefit Maximum	45 days
Rehabilitation Therapy - Benefit Area “C”	
Calendar Year Inpatient Benefit Maximum	\$25,000
Rehabilitation Therapy - Benefit Area “D”	
Combined Calendar Year Outpatient Benefit Maximum	\$2,000
Home Health Care Benefits - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Hospice Care - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Ambulance Service - Benefit Area “E”	
Calendar Year Benefit Maximum	\$2,000
Durable Medical Equipment - Benefit Area “E”	
Calendar Year Benefit Maximum	\$10,000

CATASTROPHIC “A” BENEFIT PLAN (continued)
Schedule of Benefits (continued)

Psychiatric and Substance Abuse Services - Benefit Area “F”	
Covered benefit as an inpatient or outpatient combined	
Calendar Year Benefit Maximum	\$5,000
Pharmacy - Benefit Area “G”	
Calendar Year Pharmaceutical Deductible - Individual	\$500
Benefit Percentage	50%
Coinsurance Percentage	50%
Does not apply to Out-of-Pocket Expense limit	
Benefits are limited to a thirty (30) day supply	

CATASTROPHIC “B” BENEFIT PLAN
Schedule of Benefits

All Benefit Areas - Lifetime Benefit Maximum per Carrier	\$1,000,000
Preventive Services - Benefit Area “A”	
Calendar Year Benefit Maximum	\$200
Subject to Deductible and Coinsurance	
Mammography benefits are not limited to the preventive services benefit	
Benefit Areas B, C, D, E, F	
Calendar Year Deductible - Individual	\$5,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Individual Out-of-Pocket Expense Maximum not including Deductible or Copayments	\$10,000
Normal Maternity Benefit Deductible - Benefit Area “B”	\$5,000
Not applicable to involuntary complications of pregnancy	
Organ Transplant - Benefit Area “C”	
Lifetime Maximum Benefit	\$250,000
Skilled Nursing Facility - Benefit Area “C”	
Calendar Year Benefit Maximum	45 days
Rehabilitation Therapy - Benefit Area “C”	
Calendar Year Inpatient Benefit Maximum	\$25,000
Rehabilitation Therapy - Benefit Area “D”	
Combined Calendar Year Outpatient Benefit Maximum	\$2,000
Home Health Care Benefits - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Hospice Care - Benefit Area “D”	
Calendar Year Benefit Maximum	\$5,000
Ambulance Service - Benefit Area “E”	
Calendar Year Benefit Maximum	\$2,000
Durable Medical Equipment - Benefit Area “E”	
Calendar Year Benefit Maximum	\$10,000

CATASTROPHIC “B” BENEFIT PLAN (continued)
Schedule of Benefits (continued)

Psychiatric and Substance Abuse Services - Benefit Area “F”	
Covered benefit as an inpatient or outpatient combined	
Calendar Year Benefit Maximum	\$5,000
Pharmacy - Benefit Area “G”	
Calendar Year Pharmaceutical Deductible - Individual	\$500
Benefit Percentage	50%
Coinsurance Percentage	50%
Does not apply to Out-of-Pocket Expense limit	
Benefits are limited to a thirty (30) day supply	

HSA COMPATIBLE PLAN (continued)
Schedule of Benefits (continued)

Psychiatric and Substance Abuse Services - Benefit Area “F”	
Covered benefit as an inpatient or outpatient combined	
Calendar Year Benefit Maximum	\$5,000
Pharmacy - Benefit Area “G”	
Calendar Year Pharmaceutical Benefit Maximum	\$6,000
Benefits are limited to a thirty (30) day supply	

GENERAL PROVISIONS

The Amount of Coverage: The amount of coverage for your classification, the applicable Deductible, Benefit Percentage, Coinsurance Percentage, Copayment, Out-of-Pocket Expense, and Benefit Maximum limitations are shown in the Schedule of Benefits.

Claims Appeal Process: In the event an Individual disputes any decision concerning payment or denial of a medical Expense claim, the Individual has the right to appeal the decision. Appeals are to be directed to the Carrier. An Individual has sixty (60) days from date of denial to request an appeal. The initial appeal can be made verbally or in writing.

After the receipt of the initial request for appeal, the Carrier will attempt to resolve the dispute on an informal basis directly with the Individual.

If the initial appeal is not resolved to the Individual's satisfaction, the Individual may appeal a second time. The second appeal must be in writing and must be submitted within sixty (60) days of the Carrier's written denial. Following receipt of the written appeal and all pertinent data, the Carrier will direct the appeal for prompt review to a grievance panel before whom the Individual has the right either to appear or be heard or both.

Renewability of Coverage: This Health Benefit Plan is subject to the provisions of Idaho Code 41-5207, and shall be renewable with respect to the Individual or Dependents, at the option of the Individual, except in any of the following cases:

- a. Non-payment of required Premiums;
- b. Fraud or intentional misrepresentation of material fact by the Individual Insured or his representatives. An Individual whose coverage is terminated for fraud or misrepresentation shall not be deemed to be an "Eligible Individual" for a period of twelve (12) months from the effective date of the termination of the Individual's coverage and shall not be deemed to have "Qualifying Previous Coverage" under chapter 22, 47, 52 or 55 Title 41, Idaho Code;
- c. The Individual ceases to be an Eligible Individual as defined in section 41-5203 (10), or 41-5510, Idaho Code;
- d. In the case of Health Benefit Plans that are made available in the individual market only through one (1) or more associations, as defined in section 41-2202, Idaho Code, the membership of an Individual in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered Individual;

- e. The Individual Carrier elects to nonrenew all of its Health Benefit Plans delivered or issued for delivery to Individuals in this state. In such a case the Carrier shall:
 - i. Provide advance notice of its decision under this paragraph to the director; and
 - ii. Provide notice of the decision not to renew coverage to all affected Individuals and to the director at least one hundred eighty (180) days prior to the nonrenewal of any Health Benefit Plans by the Carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected Individuals; or

- f. The director finds that the continuation of the coverage would:
 - i. Not be in the best interests of the policyholders or certificate holders; or
 - ii. Impair the Carrier's ability to meet its contractual obligations.

In such instance, the director shall assist affected Individuals in finding replacement coverage.

Subrogation Rights of Carrier: The benefits of this policy will be available to an Individual when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for covered services are provided or paid for by the Carrier under this policy, the Carrier shall be subrogated and succeed to the rights of the Individual or, in the event of the Individual's death, to the rights of his or her heirs, estate and/or personal representative.

As a condition of receiving benefits for covered services in such an event, the Individual or his or her personal representative shall furnish the Carrier in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss. The Individual shall fully cooperate with the Carrier in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Carrier's Subrogation Rights and efforts.

Insurance Provision: If you or your Dependent, while insured under this policy, incurs an "Eligible Expense" for covered services because of an injury or sickness, the policy will pay a percentage of the "Eligible Expense" after the Deductible and Copayment or Coinsurance are satisfied. The policy will pay up to the maximum benefit for each Insured person. The applicable Benefit Percentage payable, Deductible, Coinsurance or Copayment and Maximum Benefits are shown in the Schedule of Benefits.

PREVIEW SECTION

Proposed inpatient admission and attendant course of treatment during that admission shall be evaluated by the Carrier, which shall approve or disapprove such benefits.

1. **“Preadmission Review.”** An evaluation by the Carrier of an Individual’s proposed inpatient admission to a facility. The medical necessity and reasonableness of the proposed course of inpatient treatment.

Preadmission Review is required for all inpatient admissions of an Individual except covered services subject to Emergency Admission Review.

A request for Preadmission Review must be made to the Carrier by the Individual as soon as the Individual knows that he or she will be admitted as an inpatient and must be made prior to any inpatient admission unless Preadmission Review is not required as specified above.

Within two (2) business days (unless exceptional circumstances warrant a longer period to evaluate a request), after complete medical information is provided to the Carrier, the Carrier shall notify the Individual and the Providers involved of its determination.

2. **“Emergency Admission Review.”** When an unplanned inpatient admission occurs for Emergency Services, and Preadmission Review cannot be completed, no Carrier shall require prior authorization for Emergency Services.

3. **“Continued Stay Review.”** The Carrier shall contact the attending Provider the day before the Individual is proposed to be discharged. If the Individual will not be discharged as originally proposed, the Carrier shall evaluate the medical necessity and reasonableness of the continued stay and approve or disapprove benefits for the proposed course of inpatient treatment. The Carrier will maintain qualified personnel during normal business hours for telephone responses to inquirers about medical necessity, including certification of continued length of stay.

4. **“Discharge Planning.”** The Carrier shall provide information about benefits for various post discharge courses of treatment.

5. **“Individual Benefits Management.”** Individual Benefits Management addresses, as an alternative to providing covered services, the Carrier’s discretionary consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by the Carrier in its sole discretion on a case-by-case basis. The Carrier’s determination to cover and pay for alternative benefits for an Individual shall not be deemed to waive, alter or affect the Carrier’s right to reject any other or subsequent request or recommendation. The Carrier may elect to provide alternative benefits if the Carrier and the Individual’s attending Provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, the Carrier in its discretion, concludes that substantial future expenditures for covered services for the Individual could be significantly diminished by providing such alternative benefits under the Individual Benefits Management program.

6. **“Participating Provider.”** A Provider or facility which has entered into an agreement with the Carrier and is participating with the Carrier to provide covered services to Individuals and has agreed to accept the individual policy Deductible and Coinsurance payment, plus the Carrier’s reimbursement level as payment in full.
7. **“Non-Participating Provider.”** A Provider or facility, which is not contracting with the Carrier to provide services. (Please review your Schedule of Benefits for the Carrier’s level of reimbursement to Non-Participating Providers and facilities.)
8. **“Appeals Process.”** See the policy “General Provisions” section.

COVERED SERVICES

Benefit Area “A” - Preventive Care Benefits

Benefits include diagnostic screening, early detection tests and various preventive checks. The Insured shall pay any applicable Deductible or Coinsurance percentages as shown in the Schedule of Benefits. Only one physician office visit charge per year along with the various charges for specific covered screenings is covered (except for infants under age two (2) for child health supervision) under this preventive care benefit. Charges are limited to covered “Expense” as defined in the policy. The maximum amount of benefit payable in a Calendar Year is shown in the Schedule of Benefits.

Mammograms shall not be limited to the benefit maximum.

Eligible Preventive Care Benefits include:

- Pap Smears
- Prostate Exam and PSA Testing
- Cholesterol Screening
- Stool Guaiac
- EKG Screen
- Blood Sugar Test
- PPD (TB Skin Test)
- Immunizations
- Child Health Supervision (based on the American Academy of Pediatrics recommendations)
- Preventive Office Visits
- Well-Baby Care, excluding nursery charges

Benefit Area “B” – Maternity (Basic, Standard, Catastrophic “A”, and Catastrophic “B” only)

Eligible Expenses for normal delivery or voluntary cesarean section delivery, pre-natal hospital services, assistant surgeons, anesthesiology, and other services and supplies will be covered under the usual cost share provisions on the same basis as any other covered service as defined in the Schedule of Benefits (subject to the maternity Deductible).

Covered Expenses are limited to a semi-private room rate.

Routine newborn nursery care is not considered a maternity service. Newborn nursery care benefits are available for a two (2) day stay under the Basic, Standard, Catastrophic “A”, and “B” and HSA Compatible Plans, subject to enrollment within 60 days of birth or placement for adoption. Any additional nursery charges would be subject to medical necessity.

No maternity benefits are provided under the HSA Compatible Benefit Plan; however, all plans, Basic, Standard, Catastrophic “A” and “B”, and the HSA Compatible plans will cover involuntary complications of pregnancy the same as any other illness. (Involuntary complications of pregnancy shall include but not be limited to puerperal infection, eclampsia, involuntary cesarean section delivery, ectopic pregnancy, and toxemia.)

No maternity benefits are provided for Dependent children.

No coverage will be provided for elective abortions, except to preserve the life of the Individual or spouse upon whom the abortion is performed.

Benefit Area “C” - Inpatient Services

Covered hospital services on an inpatient basis include the following:

1. Up to the average daily semi-private room and board Expenses.
2. Intensive Care Unit and Coronary Care Unit: payable at the Eligible Expense reimbursement rate.
3. Miscellaneous inpatient hospital Expenses for services and supplies.
4. For inpatient hospital surgery:
 - a. A primary surgeon’s Eligible Expense for the surgery.
 - b. An anesthetist’s fee is limited to the Eligible Expense.
 - c. An assistant surgeon’s fee where Medically Necessary is limited to the Eligible Expense.
5. Services of a radiologist, pathologist and physiotherapist.
6. In-hospital visits by a physician limited to one visit per day, per physician.
7. Skilled nursing care in an approved extended care facility.
8. Rehabilitation therapy is included on an inpatient basis when prescribed by an attending physician.

9. Organ transplant benefits will be available for Medically Necessary care. This does not include care of an experimental or investigative nature. Coverage would be based on current and acceptable procedures.
10. Covered hospital services on an in-patient basis include surgically implantable and injectable contraceptive drugs and devices or tubular ligations performed in conjunction with a cesarean section.

Benefits for these covered services are subject to the cost-sharing amount and benefit limits shown in the Schedule of Benefits.

Benefit Area “D” - Outpatient Services

Covered services on an outpatient and out-of-hospital basis are described below. These benefits are subject to the Deductible, Coinsurance and Benefit Maximums shown in the Schedule of Benefits. Benefits for mental illness and substance abuse care, for prescription drugs, and for transport and medical durable equipment are described in other areas.

Physician Visits

Covered Expenses incurred by an Individual will include physician visits other than as a hospital inpatient.

Outpatient Surgery

Expenses for surgery performed while not confined as a hospital inpatient include;

1. A primary surgeon’s Eligible Expense for surgery;
2. The fees of a radiologist or pathologist, if any; and
3. If the surgery is of a type customarily performed while hospital confined, but is performed in a licensed ambulatory free standing or outpatient surgical center:
 - a. The services and supplies of the facility;
 - b. An anesthetist’s fee is limited to Eligible Expense.
 - c. Assistant surgeon’s fee where Medically Necessary is limited to Eligible Expense.

Miscellaneous Hospital Outpatient or Out-of-Hospital Health Care Provider Services

1. Blood or blood plasma, which is not replaced.
2. Oxygen and its administration.
3. Diagnostic testing, x-ray and lab examination. Certain tests may require pre-approval by the Carrier.

4. Chemotherapy, radium and isotope therapy, renal dialysis and hemodialysis as ordered by a physician.
5. Anesthesia, not including the anesthetist's fee.
6. Miscellaneous hospital emergency room or hospital outpatient services and supplies.
7. Pre-admission testing. Certain tests may require prior approval of the Carrier.
8. Second and Third Surgical Opinion: A physician's fee for a second surgical opinion when required by the Carrier for Pre-Certification, up to a stated maximum. A physician's fee for a third surgical opinion, up to the maximum, if the second physician had felt the treatment or admission was not Medically Necessary.
9. Post Mastectomy benefits.
10. Hospice Care: Expenses incurred for Hospice Care. Any Expense for which these benefits are payable must occur while this policy is in force, and as follows:

Hospice care services must be provided by an agency meeting the regulatory requirements for Hospice Care in Idaho; and

- a. Be primarily engaged in providing:
 - i. pain relief;
 - ii. symptom management;
 - iii. support service to a dying person and their families; and
 - b. Provide nursing care under the supervision of a registered nurse. A Provider must certify that the Individual:
 - i. has no reasonable prospect for cure;
 - ii. has a life expectancy of less than six (6) months;
 - iii. needs Hospice services for palliation or management of medical and related conditions; and
 - iv. would have to be confined in a hospital or nursing home if Hospice Care services were not available.
11. Home Health Care benefits will be provided under the terms of the policy by a licensed Home Health Care Professional Agency. The requirements for coverage will include the need for a written plan of care which has been prescribed by a physician in lieu of hospitalization. Such Home Health Care benefits are not to be interpreted to be extended to cover custodial care, or care designed principally to assist an Individual in

activities of daily living or services which constitute personal care, which can usually be self-administered, and which does not entail or require the continuing attention of trained medical personnel.

12. Rehabilitation therapy is included on an outpatient basis when prescribed by an attending Provider. Rehabilitation therapy has a combined Calendar Year benefit limit for physical therapy, speech therapy, occupational therapy, and manipulative therapy and related treatments.
13. Surgically implantable and injectable contraceptive drugs and devices.
14. Mammography.

For benefit limits see the Schedule of Benefits.

Benefit Area “E” - Transportation and Medical Equipment

The following services for transportation and medical equipment are covered subject to the cost sharing amounts shown in the Schedule of Benefits.

Ambulance Service

1. Legally operated ambulance service to or from a hospital or skilled nursing home.
2. Must be Medically Necessary.

Durable Medical Equipment

Medically Necessary equipment for therapeutic purposes appropriate for use in the Insured's home which:

1. Is primarily used to serve a medical purpose and is prescribed by a medical physician or other professional Provider acting within the scope of their license.
2. Can withstand repeated use.
3. Is generally not useful to a person in the absence of illness or disease.

It is the option of the Carrier to determine if the durable medical equipment is purchased or rented. Items of equipment which are commonly purchased for home use for non-medical purposes or otherwise considered to be common household items are not covered, such as air conditioners, air purifiers, spas, hot tubs or exercise equipment, computers, etc.

Deluxe versus Standard Equipment

When standard equipment fulfills the Insured's need but the Insured chooses a deluxe model, the benefit calculation is based on the charge for the standard item. For example,

if the Insured is able to operate a standard hospital bed but chooses an electric bed for convenience, benefits are based on the cost of the standard bed. Benefits for deluxe wheelchairs and three-wheel carts are provided on the same basis.

Support Equipment

Benefits are available for Medically Necessary support and backup equipment when the primary item is covered. An example of support equipment would be replacement wheelchair batteries and a battery charger. Since oxygen enrichers and concentrators are electric, benefits would be available for a backup cylinder in case of a power failure.

Monitoring Devices

Certain items of monitoring equipment have appeared on the market which meet the definition of durable medical equipment. One example is the glucose analyzer to determine proper insulin dosage for an Insured with brittle diabetes. Benefits are allowed for this device and the necessary chem strips and lancets necessary to operate the device, since it is used to treat the Insured with brittle diabetes through close monitoring of blood sugar levels. Benefits also are allowed for the apnea monitor used in the detection of the onset of Sudden Infant Death Syndrome in babies with histories of severe respiratory disease.

Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair and replacement of Prosthetic Appliances including post-mastectomy prostheses. Prosthetic Appliances are devices that replace all or part of an absent body organ or body part, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ, or body part.

Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired, or replacement is prescribed by a physician because of a change in the Insured's physical condition.

Benefit Area "F" - Psychiatric and Substance Abuse Care

This benefit area provides coverage for psychiatric and substance abuse care performed in an outpatient or inpatient setting, subject to the cost sharing amounts and benefit limits in the Schedule of Benefits.

1. Mental Illness means a mental or nervous disorder, including neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, attention deficit hyperactivity disorder, or emotional disease or disorder of any kind.
2. Substance abuse care includes treatment for alcoholism, drug addiction and chemical dependency.
3. The benefit is limited to a stated Calendar Year maximum. This maximum includes the combined costs of mental illness treatment and substance abuse care.

4. Treatment must be physician directed.
5. Services must be provided by a licensed mental health professional or licensed substance abuse professional.

Benefit Area “G” - Pharmacy

This area provides coverage for outpatient prescription drugs and medicines, including insulin and prescription contraceptive drugs or devices, which are ordered by an attending physician. This benefit is available to the primary Insured, or Dependent. Eligible Expense includes drugs, biological and compounded prescriptions that can be dispensed only pursuant to a written prescription given by a Provider, that are Medically Necessary for care and treatment of a covered illness or injury and that are listed and accepted in the *United States Pharmacopoeia, National Formulary, or AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: “Caution – Federal Law prohibits dispensing without prescription.” Benefits are limited to a thirty (30) day supply, and the cost sharing amount in the Schedule of Benefits.

If the plan is subject to any type of utilization review for formularies, these provisions need to be set forth here.

LIMITATIONS AND EXCLUSIONS

1. **Acupuncture.** Acupuncture except when used as pain management by a licensed Provider.
2. **Artificial Insemination and Infertility Treatment.** Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease.
3. **Cosmetic Surgery.** Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child. Mastectomy reconstruction is covered as described in the “Women’s Health and Cancer Rights Act.”
4. **Custodial, Convalescent, Intermediate.** Custodial, convalescent or intermediate level care or rest cures.
5. **Dental, Temporomandibular Joint (TMJ), and Orthodontic Services.** Dental and orthodontic services except those needed for treatment of an accidental injury to sound natural teeth, incurred while covered by the plan and limited to six (6) months from the date of injury.

6. **Expenses Exceeding the Carrier's Allowable Charge.** Expenses and/or charges which exceed the Carrier's allowable charge for a service or supply.
7. **Experimental, Investigational.** Services which are experimental or investigational.
8. **Failure to Keep a Scheduled Visit.** Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information.
9. **Hearing Tests and Hearing Aids.** Hearing tests without illness being indicated. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids.
10. **Immunizations, Medical Exams and Tests.** Immunizations, medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy.
11. **Injury or Sickness.** Injury or sickness caused by war or armed international conflict or incurred as a result of voluntary participation in an assault, felony, insurrection or riot.
12. **Manipulative Therapy and Related Treatment.** Manipulative therapy, including heat treatments and ultrasound of the musculoskeletal structure and other fractures and dislocations of the extremities, will be subject to the Rehabilitation therapy benefit Area "D" limit described in the Schedule of Benefits.
13. **Marriage and Family Counseling.** Marriage and family counseling except as specifically allowed in the policy.
14. **Maternity and Routine Newborn Nursery Care.** Not a covered benefit under the HSA Compatible plan.
15. **Medical Services Received From Employer, Labor Union Association.** Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
16. **No Charges, No Legal Obligation to Pay.** Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the Insured has no legal obligation to pay.
17. **No Medical Diagnosis.** Services for weight control, nutrition, and smoking cessation, including self-help and training programs, as well as prescription drugs used in conjunction with such programs and services.
18. **Not Medically Necessary.** Any service not Medically Necessary or appropriate unless specifically included within the coverage provisions.

19. **Obesity.** Medical or surgical procedures primarily for treatment of obesity or for reversal, revision, or complications thereof.
20. **Personal Hygiene and Convenience Items.** Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment.
21. **Pre-Existing Conditions.** Pre-Existing Conditions except as provided specifically in the policy.
22. **Prior to Effective Date.** Care incurred before the effective date of the Insured's coverage.
23. **Private Duty Nursing.** Private duty nursing except as specifically allowed in the policy.
24. **Private Room.** Private room accommodation charges in excess of the institution's most common semi-private charge except when prescribed as Medically Necessary.
25. **Reversal of Elective Infertility.** Services for reversal of elective, surgically or pharmaceutically induced infertility.
26. **Screening Examinations.** Charges for screening examinations except as otherwise provided in the policy.
27. **Sex Change Operations.** Sex change operations and treatment in connection with transsexualism.
28. **Termination.** Services incurred after the date of termination of a covered person's coverage.
29. **Vision Therapy.** Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error.
30. **Weak, Strained, or Flat Feet.** For treatment of weak, strained, or flat feet, including orthopedic shoes, orthotic devices or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease.
31. **Wig or Hair Loss.** Charges for wigs or cranial prostheses, hair analysis, hair loss, and baldness.
32. **Workers Compensation, Medicare or CHAMPUS.** Services covered by Workers' Compensation, Medicare or CHAMPUS.