

CHAPTER 75
IOWA INDIVIDUAL HEALTH BENEFIT PLANS

191—75.1(513C) Purpose. This chapter is intended to implement the provisions of Iowa Code chapter 513C to promote the availability of health insurance coverage to individuals, regardless of their health status or claims experience; to prevent abusive rating practices; to require disclosure of rating practices to purchasers; to establish rules regarding the renewal of coverage; to establish limitations on the use of preexisting condition exclusions; to assure fair access to health benefit plans; to improve the overall fairness and efficiency of the individual health insurance market; and to provide for development of “basic” and “standard” health insurance plans to be offered to individuals. Carriers that provide individual health insurance benefit plans, as that term is defined in Iowa Code chapter 513C, to individuals are subject to all provisions of chapter 513C and this Chapter 75.

191—75.2(513C) Definitions. As used in this chapter:

“*Eligible resident*” means an individual who has been legally domiciled in this state for a period of 60 days. For purposes of this chapter, legal domicile is established by living in this state and obtaining an Iowa motor vehicle operator’s license, registering to vote in Iowa, or filing an Iowa income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child’s parents or the child’s guardian is legally domiciled in this state for a period of 60 days. A person with a developmental disability or another disability which prevents the person from obtaining an Iowa motor vehicle operator’s license, registering to vote in Iowa, or filing an Iowa income tax return, is legally domiciled in this state by living in the state for 60 days.

“*Insured group health plan*” as that term is referenced in Iowa Code section 513C.3 includes a health benefit plan offered directly through an employer with two or more employees and a plan offered through an employer with two or more employees under a group discretionary trust or association plan.

“*Risk characteristic*” means the health status, claims experience or any similar characteristic related to the health status or experience of an individual under a health benefit plan.

“*Risk load*” means the percentage above the applicable base premium rate that is charged by a carrier to an individual to reflect the risk characteristics of such individual.

Other terms shall be defined pursuant to Iowa Code chapter 513C.
[ARC 3682C, IAB 3/14/18, effective 4/18/18; ARC 6121C, IAB 12/29/21, effective 2/2/22]

191—75.3(513C) Applicability and scope.

75.3(1) Except as otherwise specifically provided, this chapter shall apply to any individual health benefit plan applied for on or after April 1, 1996.

75.3(2) Iowa Code chapter 513C and this chapter shall apply to an individual health benefit plan provided to an eligible individual.

75.3(3) An entity that is not operating as an individual health benefit plan carrier in this state shall not become subject to the provisions of the Act and this rule solely because an individual that was issued a health benefit plan in another state by that entity becomes a resident of this state.

75.3(4) This chapter shall not apply to health insurance policies or certificates that are subject to Iowa Code chapter 513B.

75.3(5) Except for basic or standard health benefit plans, nothing in Iowa Code chapter 513C or this chapter is applicable to underwriting practices, substandard ratings, or the addition of waivers or riders to policies or certificates.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.4(513C) Establishment of blocks of business. A carrier shall file with the commissioner the following information with respect to each established block of business, as defined in Iowa Code section 513C.3.

1. A description of each criterion employed by the carrier for determining membership in the block of business;

2. A statement describing the justification for establishing the block as a separate block of business;

3. A statement disclosing which, if any, health benefit plans are currently available for purchase in the block and any significant limitations related to the purchase of such plans.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.5(513C) Transition for assumptions of business from another carrier.

75.5(1) Transfer or assumption of insurance obligation.

a. A carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering a block of business in this state unless the transaction has been approved by the commissioner of the state of domicile of the ceding carrier.

b. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk or one or more blocks of business from another carrier shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of Iowa Code chapter 513C and this chapter.

c. The filing required under paragraph 75.5(1) “*b*” shall:

(1) Describe the block of business, including any eligibility requirements, of the ceding carrier from which the health benefit plans will be ceded;

(2) Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate block of business, pursuant to subrule 75.5(3), or will incorporate them into an existing block of business, pursuant to subrule 75.5(4). If the assumed health benefit plans will be incorporated into an existing block of business, the filing shall describe the block of business of the assuming carrier into which the health benefit plans will be incorporated;

(3) Describe whether the health benefit plans being assumed are currently available for purchase by individuals;

(4) Describe the potential effect of the assumption on the benefits provided by the health benefit plans to be assumed;

(5) Describe the potential effect of the assumption on the premiums for the health benefit plans to be assumed;

(6) Describe any other potential material effects of the assumption on the coverage provided to the individuals covered by the health benefit plans to be assumed; and

(7) Include any other information required by the commissioner.

d. A carrier required to make a filing under paragraph 75.5(1) “*b*” shall also make an informational filing with the commissioner of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under paragraph 75.5(1) “*b*” and shall include at least the information specified in subparagraph 75.5(1) “*c*”(1) for the individual health benefit plans in that state.

e. A carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless it complies with the following provisions:

(1) The carrier has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in paragraph 75.5(1) “*c*” for the health benefit plans covering individuals in this state.

(2) If the assumption of a block of business would result in the assuming carrier’s being out of compliance with the limitations related to premium rates contained in Iowa Code section 513C.5, the assuming carrier shall make a filing with the commissioner pursuant to Iowa Code section 513C.5 seeking suspension of the application of Iowa Code section 513C.5.

(3) An assuming carrier seeking suspension of the application of Iowa Code section 513C.5 shall not complete the assumption of health benefit plans covering individuals unless the commissioner grants the suspension requested pursuant to subparagraph 75.5(1) “*e*”(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of Iowa Code section 513C.5 shall, with respect to an assumed block of business, be for no more than 15 months and, with respect to each individual, last only until the anniversary date of such individual's coverage. With respect to an individual this period may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the block of business.

75.5(2) Except as provided in subrule 75.5(1), a carrier shall not cede or assume the entire insurance obligation or risk for a health benefit plan, other than reinsurance, unless the carrier cedes to the assuming carrier the entire block of business that includes such health benefit plan, unless otherwise approved by the commissioner.

75.5(3) The commissioner may approve a longer period of transition upon application of a carrier. The application shall be made within 60 days after the date of assumption of the block of business and shall clearly state the justification for a longer transition period.

75.5(4) Nothing in this rule or in Iowa Code chapter 513C is intended to:

a. Reduce or diminish any legal or contractual obligation or requirements, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier related to the transaction;

b. Authorize a carrier that is not admitted to transact the business of insurance in this state to offer health benefit plans in this state; or

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.6(513C) Restrictions relating to premium rates.

75.6(1) As provided by Iowa Code section 513C.5, each carrier must limit differences in premium due to such factors as experience and duration to the composite effect of 20 percent, 30 percent, and 30 percent. Allocation of cost differences due to experience and duration among the categories outlined in Iowa Code section 513C.5 may be determined by each carrier.

75.6(2) Nothing in this rule shall require rates be filed absent any other statutory requirements.

191—75.7(513C) Availability of coverage.

75.7(1) Except as provided in Iowa Code section 513C.7, the choice between the basic and standard health benefit plans may not be limited, restricted or conditioned upon the risk characteristics of the individuals or their dependents.

75.7(2) Insurers shall not require eligible family members to accept a basic or standard health benefit plan covering all family members. Those family members who qualify for an underwritten plan may be issued separate coverage from those who do not qualify for the underwritten plan but are eligible for guaranteed issue of the basic or standard plan.

75.7(3) Qualifying previous coverage for a newborn shall be the greater of the period or periods of qualifying previous coverage established by either of the newborn's parents prior to the date of birth.

75.7(4) Benefits paid under a basic or standard health benefit plan shall not duplicate benefits paid under any other health insurance coverage. Other coverage means benefits paid for hospital, surgical or other medical care or expenses for a covered person by any of the following:

- a. Insurance plan or policy; or
- b. Health benefit plan; or
- c. Welfare plan; or
- d. Prepayment plan; or
- e. Hospital service corporation plan or policy; or
- f. Medicare;

whether provided on an individual, family, or group basis or through an employer, union or association. If such other coverage is on a provision of service basis, the amount of benefits will be the amount that the services provided would have cost without such other coverage.

191—75.8(513C) Disclosure of information.

75.8(1) General rules. In connection with the offering for sale of a health benefit plan to individuals, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

a. The extent to which premium rates for a specified individual are established or adjusted in part based upon the actual or expected variation in claims costs or the actual or expected variation in health conditions of the individual and the individual's dependents, if any.

b. The provisions of such plan concerning the carrier's ability to change premium rates and the factors, other than claim experience, which affect changes in premium rates.

c. The provisions of such plan relating to the renewability of policies and contracts.

d. The provisions of such plan relating to the effect of any preexisting condition provision. The expression "preexisting conditions" shall not be used unless appropriately defined in the policy or contract.

e. The availability, upon request, of descriptive information about the benefits and premiums available under individual health benefit plans offered by the carrier for which the individual is qualified. For purposes of Iowa Code section 513C.7, carriers will be permitted to exclude from disclosure of plans those plans within the following categories:

- (1) Plans distributed through a separate marketing channel.
- (2) Plans offered through a membership association.
- (3) Plans offered through a trust in which membership is otherwise limited.
- (4) Other plans as reviewed and approved by the commissioner or director.

75.8(2) Information shall be provided under this rule in a manner determined to be understandable by the average individual and shall be accurate and sufficiently comprehensive to reasonably inform individuals of their rights and obligations under the plan.

Nothing in this rule supersedes the requirements for outlines of coverage for individual health insurance policies under rule 191—36.7(514D).

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.9(513C) Standards to ensure fair marketing.

75.9(1) A carrier shall make available at least one basic and one standard health benefit plan to eligible individuals in this state.

75.9(2) The written information described in this subrule may be provided directly to the individual or delivered through an authorized producer:

a. A carrier shall not apply more stringent requirements related to the application process for the basic and standard health benefit plans than applied for other health benefit plans offered by the carrier.

b. A carrier shall supply a price quote for basic or standard plans to an eligible individual upon request.

c. If a carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and state with specificity the reasons for the denial subject to any restrictions related to confidentiality of medical information. The denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the carrier and may be combined with the notification requirements of Iowa Code chapter 514E. The explanation shall include the following information about the basic and standard benefit plans:

- (1) A general description of the benefits and policy provisions contained in each plan;
- (2) A price quote for each plan; and
- (3) Information describing eligibility and how an eligible individual may enroll in such plans.

75.9(3) The carrier shall not require an individual to join or contribute to any association or group as a condition of being accepted for coverage except, if membership in an association or other group is a requirement for accepting an individual into a particular health benefit plan, a carrier may apply such requirement.

75.9(4) A carrier may not require as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

75.9(5) Carriers offering individual or group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513C. [ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.10(513C) Basic health benefit plan and standard health benefit plan policy forms.

75.10(1) The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in the rules and table.

75.10(2) Termination of pregnancy is to be covered when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard plan.

75.10(3) A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor’s license.

75.10(4) Prescription oral contraceptives and contraceptive devices that are approved by the United States Food and Drug Administration are to be covered in both policy forms.

75.10(5) The division of insurance and the department of health have available “safe harbor” policy forms for the basic and standard health benefit plans required pursuant to Iowa Code chapter 513C.

Iowa Individual Products

Hospital Services	MANDATED INDEMNITY				MANDATED HMO	
	BASIC	STANDARD	PPO		BASIC	STANDARD
			In	Out		
Inpatient	60%	80%	80%	60%	60%	80%
Outpatient					\$400/admit	\$200/admit
Prostheses	60%	80%	80%	60%	60%	80%
DME—including medical supplies	60%	80%	80%	60%	60%	80%
Ambulance—Emergency	60%	80%	80%	60%	60%	80%
Hospice	60%	80%	80%	60%	60%	80%
Home Health and Physician House Calls	60%	80%	80%	60%	60%	80%

Alcoholism Substance Abuse	MANDATED INDEMNITY				MANDATED HMO	
	BASIC	STANDARD	PPO		BASIC	STANDARD
			In	Out		
Inpatient	—	80% ⁽¹⁾	80% ⁽¹⁾	60% ⁽¹⁾	—	80%
Outpatient	—	80% ⁽¹⁾ (\$50 max. eligible fee)	80% ⁽¹⁾	60% ⁽¹⁾	—	80% (\$50 max. eligible fee)

Mental Health	MANDATED INDEMNITY				MANDATED HMO	
	BASIC	STANDARD	PPO		BASIC	STANDARD
			In	Out		
Inpatient	—	80% ⁽¹⁾	80% ⁽¹⁾	60% ⁽¹⁾	—	80%
Outpatient	—	80% ⁽¹⁾ (\$50 max. eligible fee)	80% ⁽¹⁾ (\$50 max. eligible fee)	60% ⁽¹⁾ (\$50 max. eligible fee)	—	80% (\$50 max. eligible fee)

⁽¹⁾\$50,000 Lifetime Max.

Iowa Individual Products

General	MANDATED INDEMNITY				MANDATED HMO	
	BASIC	STANDARD	PPO		BASIC	STANDARD
			In	Out		
Calendar year deductibles (S/F)	\$1,500 x 3	\$1,000 x 3	\$1,000 x 3	\$1,000 x 3	—	—
E.R. Copayment	—	—	—	—	\$50 (waived if admitted)	\$50 (waived if admitted)
Coinsurance	60%	80%	80%	60%	60%	80%
Annual out-of-pocket max. ⁽¹⁾	\$4,800/ \$14,400	\$2,000/ \$4,000	\$2,000/ \$4,000	\$3,000/ \$6,000	\$4,000/ \$8,000	\$2,000/ \$4,000
Lifetime Maximum	\$250,000	\$1,000,000	\$1,000,000	\$1,000,000	\$250,000	\$1,000,000
Pre-existing	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)
Rx	60%	80%	80%	60%	Copayment of > \$30 or 25%	Copayment of > \$20 or 25%
Transplants	None	80%	80%	80%	None	80%

⁽¹⁾Excludes deductibles and copays

Physician Services	MANDATED INDEMNITY				MANDATED HMO	
	BASIC	STANDARD	PPO		BASIC	STANDARD
			In	Out		
Office visits including wellness	60%	80%	\$20 copay 100%	\$40 copay 60%	\$20 copay per office visit	\$15 copay per office visit
Urgent Care	60%	80%	80%	60%	60%	80%
Inpatient	60%	80%	80%	60%	60%	80%
Outpatient	60%	80%	80%	60%	60%	80%

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

75.10(6) Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions;
7. For any illness or injury suffered as a result of any act of war, declared or undeclared, or military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;

9. For which no expense is incurred;
10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;
11. Rendered by a provider that is a member of the insured's immediate family;
12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;
13. Incurred after the date of termination of the insured's coverage;
14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;
16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;
17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
18. For custodial care, domiciliary care or rest cures;
19. For treatment in a facility, or part of a facility, that is mainly a place for:
 - Rest;
 - Convalescence;
 - Custodial care;
 - Aged;
 - Care or treatment of alcoholism or drug addiction;
 - Rehabilitation; or
 - Training, schooling or occupational therapy;
20. For screening examinations including X-ray examinations made without film;
21. For sterilization or reversal of sterilizations, or both;
22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;
23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;
28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;
29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;
30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;
31. For travel whether or not recommended by a physician;

32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;
 33. For maternity care except for complications of pregnancy which is covered as any other illness;
 34. For services to the extent that those services are covered by Medicare;
 35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);
 36. For or related to the transplantation of animal or artificial organs or tissues;
 37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;
 38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;
 39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;
 40. For the purchase of wigs or cranial prosthesis;
 41. For weekend admission charges, except for emergencies;
 42. For orthomolecular therapy including nutrients, vitamins and food supplements;
 43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.
- [ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.11(513C) Maternity benefit rider. Every individual insurance carrier shall offer an optional maternity benefit rider for the basic and standard health benefit plans providing benefits, as any other illness, for a pregnancy and delivery without complications with a 12-month waiting period. Credit toward meeting the waiting period shall be given for prior coverage of a pregnancy without complications provided there was no more than a 63-day break in coverage. A maternity rider offered under this rule shall only be offered when the basic or standard plan is initially purchased. Premiums for the rider shall be calculated based upon generally accepted actuarial principles and shall not be subject to the premium restrictions in Iowa Code subsection 513C.10(6). The earned premiums and paid losses associated with the rider shall not be considered by the Iowa Individual Health Benefit Reinsurance Association for purposes of Iowa Code section 513C.10.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.12(513C) Disclosure requirements. All carriers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.13(514C) Treatment options.

75.13(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

75.13(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—75.14(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

75.14(1) The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

75.14(2) The term “emergency medical condition” means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
- b. Serious impairment to bodily function; or
- c. Serious dysfunction of any bodily organ or part.

75.14(3) Reimbursement to a provider of “emergency services” shall not be denied by any carrier without that organization’s review of the patient’s medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the carrier. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and provider that they may register a complaint with the commissioner of insurance.

191—75.15(514C) Provider access. A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—75.16(513C,514C) Diabetic coverage. All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.18.

[ARC 6121C, IAB 12/29/21, effective 2/2/22]

These rules are intended to implement Iowa Code chapters 513C and 514C.

191—75.17(513C) Reconstructive surgery.

75.17(1) A carrier that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

75.17(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

75.17(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

75.17(4) A carrier shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements

of this rule. A carrier shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—75.18(514C) Contraceptive coverage.

75.18(1) A carrier that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

75.18(2) A carrier is not required to offer benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

75.18(3) A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

75.18(4) A carrier shall make available benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

75.18(5) If a carrier does not provide benefits for a routine physical examination, the carrier is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement Iowa Code chapter 514C.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

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