"Exhaustion of continuation coverage" means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted continuation coverage if:

1. Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or

2. When the individual no longer resides, lives, or works in a service area of an HMO or similar program, whether or not within the choice of the individual, and there is no other continuation coverage available to the individual.

"Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1. For purposes of this rule, "medical care" means amounts paid for any of the following:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
- Transportation primarily for and essential to medical care referred to in this definition.
- Insurance covering medical care referred to in this definition.

2. For purposes of this division, a plan, fund, or program established or maintained by a partnership which, but for this paragraph, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

3. With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

4. With respect to a group health plan the term "participant" includes the following:

- With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.
- With respect to a group health plan maintained by a self-employed individual, under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

"Health insurance coverage" or *"Health insurance plan"* means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

1. "Health insurance coverage" does not include any of the following:

- Coverage for accident only, or disability income insurance.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinic care.

- Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- Flexible spending accounts.

2. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

- Limited scope dental or vision benefits.
- Benefits for long-term care, nursing home care, home health care, or community-based care.
- Short-term limited durational insurance.
- Any other similar, limited benefits as provided by rule of the commissioner.
- Stop loss insurance coverage.

3. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance.

4. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided under insurance coverage.

5. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

"Health maintenance organization" or *"HMO"* means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514B.5.

"Large employer" means an employer employing two or more employees and which does not meet the definition of small employer under Iowa Code section 513B.2(16).

"Late enrollee" means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or health insurance coverage in connection with which it is issued, other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or health insurance coverage.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

"Organized delivery system" or *"ODS"* means an organized delivery system licensed by the director.

"Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible/limit year used under the plan.
2. If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.
3. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year.

"Preexisting condition exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's consent, that is, within 12 months of the date the contract becomes effective.

"Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

"Special enrollment period" means a period other than the first period in which an eligible employee or a dependent is eligible to enroll under the terms of group health insurance coverage in connection with which it is issued, without regard to other enrollment periods defined under the health insurance coverage.

"Waiting period" means, with respect to group health insurance coverage and an eligible employee or a dependent who is potentially eligible for coverage under the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

191—35.24(509) Eligibility to enroll.

35.24(1) A carrier or an organized delivery system offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.
b. Medical condition, including both physical and mental conditions.
c. Claims experience.
d. Receipt of health care.
e. Medical history.
f. Genetic information.
g. Evidence of insurability, including conditions arising out of acts of domestic violence.
h. Disability.

35.24(2) Subrule 35.24(1) does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

35.24(3) Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting or affiliation periods for such enrollment.

35.24(4) A carrier or organized delivery system offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage. This subrule shall not be construed to do either of the following:

a. Restrict the amount that an employer may be charged for health insurance coverage.

b. Prevent a carrier or organized delivery system offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

35.24(5) A carrier or organized delivery system shall not modify a health insurance coverage with respect to an employer or any eligible employee or dependent through riders, endorsements or other means, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the health insurance coverage.

191—35.25(509) Special enrollments.

35.25(1) A carrier or organized delivery system shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health insurance coverage, if an eligible employee requests enrollment or, if the group health insurance coverage makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health insurance coverage, during the special enrollment period, which shall be 30 days following an event described in subrules 35.25(2) or 35.25(3) with respect to the individual for whom enrollment is requested. A carrier or organized delivery system may impose enrollment requirements that are otherwise applicable under terms of the group health insurance coverage to individuals requesting immediate enrollment.

35.25(2) An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health insurance coverage, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health insurance coverage, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health insurance coverage, group health plan, or otherwise; and

b. When enrollment was declined for the individual:

(1) The individual had coverage under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

c. For purposes of subparagraph 35.25(2)*"b"*(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health insurance coverage; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

(3) Exhaustion of COBRA continuation coverage means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if the coverage ceases.

35.25(3) If the eligible employee has previously declined enrollment under the group health insurance coverage but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

35.25(4) Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

191—35.26(509) Group health insurance coverage policy requirements.

35.26(1) Group health insurance coverage subject to the rules in this division is renewable with respect to all eligible employees or their dependents at the option of the employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay or to make timely payments of premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsors, performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's or organized delivery system's minimum participation requirements or employer contribution requirements.

d. For a network plan, no enrollees connected to the plan live, reside, or work in the service area of the issuer.

e. A carrier or ODS may choose to discontinue offering and cease to renew a particular type of health insurance coverage in the large group market if the carrier does all of the following:

(1) Provides advance notice of its decision to discontinue the plan to the commissioner or director a minimum of three days prior to the notice for affected employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew a plan to all affected employers, participants, and beneficiaries no less than 90 days prior to nonrenewal of a plan.

(3) Offers to each plan sponsor of the discontinued coverage the option to purchase any other coverage currently offered by the carrier or ODS to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph 35.26(1)*"e"*(3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier or ODS to discontinue offering and cease to renew all of its health insurance delivered or issued for delivery to employers in this state shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph 35.26(1)*"f"*(2) to affected employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected employers, participants, and beneficiaries no less than 180 days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to employers in this state and cease renewal of such coverage.

g. The membership of an employer in a bona fide association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this subrule occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner or director finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's or ODS's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier or ODS may modify the health insurance coverage for a product offered under group health insurance coverage in the group market, if such modification is consistent with the laws of this state and is effective on a uniform basis among group health insurance coverage with that product.

35.26(2) A carrier or ODS that elects not to renew health insurance coverage under 35.26(1)*"f"* shall not write any new business in the group market in this state for a period of five years after the date of notice to the commissioner or director.

35.26(3) This rule applies only to a carrier or ODS doing business in one established geographic service area of the state and the carrier's or ODS's operations in that service area.

35.26(4) Preexisting condition exclusions.

a. A carrier or ODS, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to 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 within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier or ODS offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier or ODS shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this paragraph, "affiliation period" means a period of time not to exceed 60 days for new entrants and not to exceed 90 days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors.

d. A group health plan, carrier, or ODS offering group health insurance under the plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant under rule 35.29(509).

191—35.27(509) Methods of counting creditable coverage.

35.27(1) For purposes of reducing any preexisting condition exclusion period, a group health plan, carrier, or ODS offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in paragraph 35.27(1)*"a,"* except that the plan, carrier or ODS may use the alternative method under paragraph 35.27(1)*"b"* with respect to any or all of the categories of benefits described under paragraph 35.27(1)*"d."*

a. Under the standard method, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

(1) For purposes of reducing the preexisting condition exclusion period, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(2) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(3) Notwithstanding any other provisions of paragraph 35.27(1)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 35.27(1)*"b."*

b. Under the alternative method, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in paragraph 35.27(1)*"d"* and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 35.27(1)*"a."*

c. A plan, carrier, or ODS using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

d. The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(1) Mental health.

(2) Substance abuse treatment.

(3) Prescription drugs.

(4) Dental care.

(5) Vision care.

e. If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

(3) Count creditable coverage within a category if any level of benefits is provided within the category.

191—35.28(509) Certificates of creditable coverage.

35.28(1) Group health plans, carriers, or ODSs shall issue certificates of creditable coverage to persons losing coverage. A group health plan, carrier, or ODS required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. Automatically upon the termination of an individual's group coverage;

b. Automatically upon the termination of COBRA coverage;

c. Upon request within 24 months after coverage ends.

35.28(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. The individual requesting the certificate is not entitled to receive a certificate;

b. The individual requests that the certificate be sent to another plan, carrier, or ODS;

c. The plan, carrier, or ODS receiving the certificate agrees to accept the information through means other than a written certificate;

d. The plan or carrier receiving the certificate receives the certificate within a reasonable amount of time.

35.28(3) Required information. The certificate shall include the following information:

a. The date the certificate is issued;

b. The name of the group plan providing coverage;

c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;

d. The plan administrator's name, address and telephone number;

e. A telephone number to call for further information if different from above;

f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;

g. The date creditable coverage ended or an indication that the coverage is in force.

35.28(4) Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

35.28(5) Dependent coverage transition rule. A group health plan, carrier, or ODS that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

35.28(6) Delivering certificates. The certificate shall be given to the individual, plan, carrier, or ODS requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

35.28(7) A group health plan, carrier, or ODS shall establish a procedure for individuals to request and receive certificates.

35.28(8) A certificate is not required to be furnished until the group health plan, carrier, or ODS knows or should have known that dependent's coverage terminated.

35.28(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan, carrier, or ODS shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

191—35.29(509) Notification requirements.

35.29(1) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents that includes the following:

a. The existence of any preexisting condition exclusions.

b. A determination that the group health plan, carrier, or ODS intends to impose a preexisting condition exclusion and:

(1) The basis for the decision to do so;

(2) The length of time to which the exclusion will apply;

(3) The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion;

(4) The right of the person to demonstrate creditable coverage including the right of the person to request a certificate from a prior group health plan, carrier, or ODS and a statement that the current group health plan, carrier, or ODS will assist in obtaining the certificate.

c. That the group health plan, carrier, or ODS will use the alternative method of counting creditable coverage.

d. Special enrollment rights when an employee declines coverage for the employee or dependents.

35.29(2) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of a modification of a prior creditable coverage decision when the group health plan, carrier, or ODS subsequently determines either no or less creditable coverage existed provided that the group health plan, carrier, or ODS acts according to its initial determination until the final determination is made.

191—35.30(509) Mental health benefits.

35.30(1) A carrier or organized delivery system offering mental health benefits shall not set annual or lifetime dollar limits on mental health benefits that are lower than limits for medical and surgical benefits. Health insurance coverage that does not impose an annual or lifetime dollar limit on medical and surgical benefits shall not impose a dollar limit on mental health benefits.

35.30(2) This rule does not apply to benefits for substance abuse or chemical dependency. This rule does not apply to health insurance coverage if costs increase 1 percent or more due to the application of these requirements. The calculation and notification requirements of the 1 percent exemption shall be performed pursuant to 45 CFR Part 146.136.

35.30(3) This rule applies to health insurance coverage for plan years beginning on or after January 1, 1998, and will cease to apply to benefits for services furnished on or after September 30, 2001.

191—35.31(509) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all carriers and ODSs 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 and ODSs 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.

191—35.32(514C) Treatment options.

35.32(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.

35.32(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—35.33(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency 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.

35.33(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.

35.33(2) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a 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.

35.33(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 the provider that they may register a complaint with the commissioner of insurance.

191—35.34(514C) Provider access. A carrier subject to this chapter shall allow an enrollee direct access to an obstetrician or gynecologist for routine and preventive health care services. The carrier shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 509 and 514C and 1999 Iowa Acts, Senate File 276.

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