509.3 Provisions as part of accident or health policy.

All policies of group accident or health insurance or combination thereof issued in this state shall contain in substance the following provisions:

1. The policy shall have a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued or shall be furnished to the policyholder within thirty days after the policy is issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person.

2. A provision that the company will issue to the policyholder for delivery to each person insured under such policy an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, to whom the insurance benefits are payable, and such provisions of the policy as are, in the opinion of the commissioner of insurance, necessary to inform the holder thereof as to the holder's rights under the policy.

3. A provision that to the group or class thereof originally insured shall be added, from time to time, all new persons eligible to insurance in such group or class.

4. A provision that if the insurance on a person or insurance on a person and the person's dependents covered by the policy ceases because of termination of employment or of membership in the class, the person and the person's dependents may continue their accident or health insurance under the group policy and may subsequently apply for a converted policy without evidence of insurability, as provided in chapter 509B.

5. A provision shall be made available to policyholders, under group policies covering vision care services or procedures, for payment of necessary medical or surgical care and treatment provided by an optometrist licensed under chapter 154 if the care and treatment are provided within the scope of the optometrist's license and if the policy would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148 or 150A. The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for services which may be provided by an optometrist is rejected for all providers of similar vision care services as licensed under chapter 148, 150A, or 154. This subsection applies to group policies delivered or issued for delivery after July 1, 1983, and to existing group policies on their next anniversary or renewal date, or upon expiration of the applicable collective bargaining contract, if any, whichever is later. This subsection does not apply to blanket, short-term travel, accident-only, limited or specified disease, or individual or group conversion policies, or policies designed only for issuance to persons for coverage under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

6. A provision shall be made available to policyholders under group policies covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis or treatment provided by a chiropractor licensed under chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license and if the policy would pay or reimburse for the diagnosis or treatment by a person licensed under chapter 148, 150, or 150A of the human ailment, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailment or its diagnosis or its treatment. The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for diagnosis or treatment of a human ailment by a chiropractor is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148, 150, 150A, or 151. A policy of group health insurance may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148, 150, 150A, and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based directly or indirectly upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This

subsection applies to group policies delivered or issued for delivery after July 1, 1986, and to existing group policies on their next anniversary or renewal date, or upon expiration of the applicable collective bargaining contract, if any, whichever is later. This subsection does not apply to blanket, short-term travel, accident-only, limited or specified disease, or individual or group conversion policies, or policies under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

7. A provision shall be made available to policyholders, under group policies covering hospital, medical, or surgical expenses, for payment of covered services determined to be medically necessary provided by registered nurses certified by a national certifying organization, which organization shall be identified by the Iowa board of nursing pursuant to rules adopted by the board, if the services are within the practice of the profession of a registered nurse as that practice is defined in section 152.1, under terms and conditions agreed upon between the insurer and the policyholder, subject to utilization controls. This subsection shall not require payment for nursing services provided by a certified nurse practicing in a hospital, nursing facility, health care institution, physician's office, or other noninstitutional setting if the certified nurse is an employee of the hospital, nursing facility, health care institution, physician, or other health care facility or health care provider. This subsection applies to group policies delivered or issued for delivery in this state on or after July 1, 1989, and to existing group policies on their next anniversary or renewal dates, or upon expiration of the applicable collective bargaining contract, if any, whichever is later. This subsection does not apply to blanket, short-term travel, accident-only, limited or specified disease, or individual or group conversion policies, policies rated on a community basis, or policies designed only for issuance to persons for eligible coverage under Title XVIII of the federal Social Security Act, or any other similar coverage under a state or federal government plan.

In addition to the provisions required in subsections 1 through 7, the commissioner shall require provisions through the adoption of rules implementing the federal Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.

[C24, 27, 31, § 8677, 8678; C35, § 8684-e4, -e6; C39, § **8684.04, 8684.06;** C46, § 509.4, 509.6; C50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, § 509.3]

83 Acts, ch 166, § 1; 84 Acts, ch 1290, § 1; 86 Acts, ch 1124, § 8; 86 Acts, ch 1180, § 2; 89 Acts, ch 164, § 2; 97 Acts, ch 103, §1; 99 Acts, ch 75, §2; 2005 Acts, ch 70, §7