**514.7 Contracts — approval by commissioner — provisions to be available.**

1. The contracts by any such corporation with the subscribers for health care service shall at all times be subject to the approval of the commissioner of insurance. The commissioner shall require that participating pharmacies be reimbursed by the pharmaceutical service corporation at rates or prices equal to rates or prices charged nonsubscribers, unless the commissioner determines otherwise to prevent loss to subscribers.

2. A provision shall be available in approved contracts with hospital and medical service corporate subscribers under group subscriber contracts or plans 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 subscriber contract would pay for the care and treatment if it were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148. The subscriber contract shall also provide that the subscriber 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 or 154. This subsection applies to group subscriber contracts delivered after July 1, 1983, and to group subscriber contracts on their anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This subsection does not apply to contracts designed only for issuance to subscribers eligible for coverage under Tit. XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

3. A provision shall be made available in approved contracts with hospital and medical subscribers under group subscriber contracts or plans 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 subscriber contract would pay or reimburse for the diagnosis or treatment of the human ailments, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailments or their diagnosis or treatment, if it were provided by a person licensed under chapter 148. The subscriber contract shall also provide that the subscriber 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 or 151. A group subscriber contract may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148 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 upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This subsection applies to group subscriber contracts delivered after July 1, 1986, and to group subscriber contracts on their anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This subsection does not apply to contracts designed only for issuance to subscribers eligible for coverage under Tit. XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

4. A provision shall be available in approved contracts with hospital and medical service corporate subscribers under group subscriber contracts or plans covering medical and surgical service, for payment of covered services determined to be medically necessary provided by certified 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 corporation and subscriber group, subject to utilization controls. This subsection shall not require payment for nursing services provided by a certified registered nurse practicing in a hospital, nursing facility, health care institution, a physician's office, or other noninstitutional setting if the certified registered 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 subscriber contracts delivered in this state on or after July 1, 1989, and to group subscriber contracts on their anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This subsection does not apply to limited or specified disease or individual contracts or contracts designed only for issuance to subscribers eligible for coverage under Tit. XVIII of the federal Social Security Act, contracts which are rated on a community basis, or any other similar coverage under a state or federal government plan.

[C39, §**8895.07;** C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §514.7]

83 Acts, ch 166, §2; 84 Acts, ch 1122, §6; 84 Acts, ch 1290, §2; 86 Acts, ch 1180, §5; 89 Acts, ch 164, §3; 99 Acts, ch 75, §3; 2000 Acts, ch 1058, §46; 2008 Acts, ch 1088, §126; 2010 Acts, ch 1061, §180

Federal Act reference updated pursuant to Code editor directive