514B.1 Definitions — services required or available.

As provided in this chapter, unless the context otherwise requires:

1. *"Basic health care services"* means services which an enrollee might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services rendered within or outside of a hospital.

2. *"Commissioner"* means the commissioner of insurance.

3. *"Enrollee"* means an individual who is enrolled in a health maintenance organization.

4. *"Evidence of coverage"* means any certificate, agreement or contract issued to an enrollee setting out the coverage to which the enrollee is entitled.

5. *a. "Health care services"* means services included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of all other services for the purposes of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

b. The health care services available to enrollees under prepaid group plans covering vision care services or procedures shall include a provision for payment of necessary medical or surgical care and treatment provided by an optometrist licensed under chapter 154, if performed within the scope of the optometrist's license, and the plan would pay for the care and treatment when the care and treatment were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148. The plan shall provide that the plan enrollees may reject the coverage for services which may be provided by an optometrist if the coverage is rejected for all providers of similar vision care services as licensed under chapter 148 or 154. This paragraph applies to services provided under plans made after July 1, 1983, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to enrollees eligible for coverage under Tit. XVIII of the Social Security Act or any other similar coverage under a state or federal government plan.

c. The health care services available to enrollees under prepaid group plans covering diagnosis and treatment of human ailments shall include a provision for payment of 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 plan would pay or reimburse for the diagnosis or treatment of 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, if it were provided by a person licensed under chapter 148. The plan shall also provide that the plan enrollees may reject the coverage for diagnosis or treatment of a human ailment by a chiropractor if the coverage is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148 or 151. A prepaid group plan of health care services 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 paragraph applies to services provided under plans made after July 1, 1986, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to enrollees eligible for coverage under Tit. XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

d. The health care services available to enrollees under prepaid group plans covering hospital, medical, or surgical expenses, may include, at the option of the employer purchaser, a provision for payment of covered services determined to be medically necessary provided by a certified registered nurse 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 employer purchaser and the health maintenance organization, subject to utilization

controls. This paragraph 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 paragraph applies to services provided under plans within this state made on or after July 1, 1989, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is later. This paragraph does not apply to enrollees eligible for coverage under an individual contract or coverage designed only for issuance to enrollees eligible for coverage under Tit. XVIII of the federal Social Security Act, or under coverage which is rated on a community basis, or any other similar coverage under a state or federal government plan.

6. *"Health maintenance organization"* means any person, who:

a. Provides either directly or through arrangements with others, health care services to enrollees on a fixed prepayment basis;

b. Provides either directly or through arrangements with other persons for basic health care services; and,

c. Is responsible for the availability, accessibility and quality of the health care services provided or arranged.

7. *"Provider"* means any physician, hospital, or person as defined in chapter 4 which is licensed or otherwise authorized in this state to furnish health care services.

[C75, 77, 79, 81, §514B.1]

83 Acts, ch 166, §3; 84 Acts, ch 1290, §3; 86 Acts, ch 1180, §7; 89 Acts, ch 164, §5; 99 Acts, ch 75, §4; 2008 Acts, ch 1088, §128; 2010 Acts, ch 1061, §180; 2010 Acts, ch 1193, §71

Federal Act reference updated pursuant to Code editor directive