514E.7 Policies — eligible persons — dependent coverage — preexisting conditions.

1. *a.* An individual who is and continues to be a resident is eligible for plan coverage if evidence is provided of any of the following:

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one carrier or organized delivery system.

(2) A refusal by a carrier or organized delivery system to issue insurance except at a rate exceeding the plan rate.

(3) That the individual is a federally defined eligible individual.

(4) That the individual has a health condition that is established by the association's board of directors, with the approval of the commissioner, to be eligible for plan coverage.

(5) That the individual has coverage under a basic or standard health benefit plan under chapter 513C.

b. A rejection or refusal by a carrier or organized delivery system offering only stoploss, excess of loss, or reinsurance coverage with respect to an applicant under subparagraphs (1) and (2) is not sufficient evidence for purposes of this subsection.

c. The association shall rescind coverage for an individual who no longer resides in the state.

2. *a.* An association policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, terminates at twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be both of the following:

(1) Incapable of self-sustaining employment by reason of an intellectual disability or physical disability.

(2) Primarily dependent for support and maintenance upon the person in whose name the contract is issued.

b. Proof of incapacity and dependency must be furnished to the carrier within one hundred twenty days of the person's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two-year period following the person's attainment of the limiting age.

3. An association policy that provides coverage for a family member of the person in whose name the contract is issued shall also provide, as to the family member's coverage, that the health insurance benefits applicable for children include the coverage required under section 514C.1.

4. *a.* A preexisting condition exclusion shall not apply to a federally defined eligible individual.

b. Plan coverage shall not impose any preexisting condition exclusion as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-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 thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

(4) In the case of an individual transferring to an association policy from a basic or standard health benefit plan under chapter 513C beginning on or after January 1, 2005.

c. Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage for preexisting conditions. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided both of the following apply:

(1) Application for association coverage is made no later than sixty-three days following such involuntary termination and, in such case, coverage under the plan is effective from the date on which such prior coverage was terminated.

(2) The applicant is not eligible for continuation rights that would provide coverage substantially similar to plan coverage.

d. This subsection does not prohibit preexisting conditions coverage in an association policy that is more favorable to the insured than that specified in this subsection.

e. If the association policy contains a waiting period for preexisting conditions, an insured may retain any existing coverage the insured has under an insurance plan that has coverage equivalent to the association policy for the duration of the waiting period only.

5. An individual is not eligible for coverage by the association if any of the following apply:

a. The individual is at the time of application eligible for health care benefits under chapter 249A.

b. The individual has terminated coverage by the association within the past twelve months, except that this paragraph does not apply to an applicant who is a federally eligible individual.

c. The individual is an inmate of a public institution, except that this paragraph does not apply to an applicant who is a federally defined eligible individual.

d. The individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of the employee, of a government agency or health care provider.

e. The individual, on the effective date of the coverage applied for, has not been rejected for, already has, or will have coverage similar to an association policy as an insured or covered dependent. This paragraph does not apply to an applicant who is a federally eligible individual.

f. The individual is eligible for Medicare based upon age.

6. The association is not required to make plan coverage available to an individual who is covered or is eligible for any continued group coverage under Internal Revenue Code § 4980B, the federal Employee Retirement Income Security Act of 1974, codified at 29 U.S.C. § 1001 et seq., the federal Public Health Service Act of July 1, 1944, codified at 42 U.S.C. § 201 et seq., or any continued group coverage required by the state. For purposes of this subsection, an individual who would have been eligible for such continuation of group coverage, but is not eligible solely because the individual or other responsible party failed to make the required election of coverage during the applicable time period, or terminated such coverage prior to the end of such applicable time period, shall be deemed to be eligible for such group coverage until the date on which the individual's continuing group coverage would have expired had an election been made or a termination not occurred.

86 Acts, ch 1156, §7; 90 Acts, ch 1163, §1 – 3; 96 Acts, ch 1129, §113; 97 Acts, ch 103, §52, 53; 98 Acts, ch 1100, §71; 2004 Acts, ch 1110, §48, 49; 2004 Acts, ch 1158, §15 – 17; 2005 Acts, ch 70, §17, 51; 2006 Acts, ch 1117, §64; 2008 Acts, ch 1123, §27; 2012 Acts, ch 1019, §136

[T] Subsection 2, paragraph a, subparagraph (1) amended