513C.7 Availability of coverage.

1. *a.* A carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, the basic or standard health benefit plan. A basic or standard health benefit plan filed pursuant to this paragraph may be used by a carrier beginning thirty days after it is filed unless the commissioner disapproves of its use.

b. The commissioner may at any time, after providing notice and an opportunity for a hearing to the carrier, disapprove the continued use by a carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

2. The individual basic or standard health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition shall not be defined more restrictively than any of the following:

a. A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage.

b. A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

c. A pregnancy existing on the effective date of coverage.

3. A carrier shall not modify a basic or standard health benefit plan with respect to an individual or dependent through riders, endorsements, or other means to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

95 Acts, ch 5, §9; 97 Acts, ch 103, §37 – 39; 99 Acts, ch 165, §9, 10; 2003 Acts, ch 91, §24; 2004 Acts, ch 1158, §2, 21; 2008 Acts, ch 1188, §40, 41, 43; 2012 Acts, ch 1023, §157; 2017 Acts, ch 148, §54, 55