

CHAPTER 36
INDIVIDUAL ACCIDENT AND HEALTH—MINIMUM
STANDARDS AND RATE HEARINGS
[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
MINIMUM STANDARDS

191—36.1(514D) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514D so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations which may be misleading or confusing in connection either with the purchase of the coverages or with the settlement of claims and to provide for full disclosure in the sale of the coverages.

191—36.2(514D) Applicability and scope. This chapter shall apply to all individual accident and sickness insurance policies and subscriber contracts of service corporations, organized under Iowa Code chapter 514, delivered or issued for delivery to any person in this state on and after the effective date hereof, except it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this chapter. The requirements contained in this chapter shall be in addition to any other applicable regulations previously adopted.

191—36.3(514D) Effective date. This chapter shall be effective on December 31, 1981, and shall be applicable to all new filings of individual accident and sickness insurance policies and nonprofit hospital, medical and dental service contracts made after that date, and all other policies and contracts covered by this chapter and delivered or issued for delivery after June 30, 1982, shall be in compliance with this chapter.

191—36.4(514D) Policy definitions. Except as provided hereafter, no individual accident or sickness insurance policy or hospital, medical, or dental service corporation subscriber contract delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this rule.

36.4(1) *“One period of confinement”* means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

36.4(2) *“Hospital”* may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

a. The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:

- (1) Be an institution operated pursuant to law; and
- (2) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- (3) Provide 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

b. The definition of the term “hospital” may state that the term shall not be inclusive of:

- (1) Convalescent homes, convalescent, rest, or nursing facilities; or
- (2) Facilities primarily affording custodial, educational or rehabilitative care; or
- (3) Facilities for the aged, drug addicts or alcoholics; or
- (4) Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except where a legal liability exists for charges made to the individual.

36.4(3) "*Nursing facility*" shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

- (1) Be operated pursuant to law;
- (2) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

- (3) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

- (4) Provide continuous 24-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

- (5) Maintains a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not be inclusive of:

- (1) Any home, facility or part thereof used primarily for rest;
- (2) A home or facility for the aged or for the care of drug addicts or alcoholics; or
- (3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

36.4(4) "*Skilled nursing care*" and "*convalescent nursing care*," when used in a policy, shall be defined in the policy as follows: Skilled nursing care or convalescent nursing services means any treatment which is rehabilitative in nature, which is required to restore an individual to the individual's prior level of health after an accident or illness and hospitalization, and which is related to the condition which was the cause of the confinement. Skilled nursing care and convalescent nursing care are any level of care greater than custodial care.

36.4(5) "*Custodial nursing care*" shall be defined as that level of nursing care required to assist an individual in meeting day-to-day living requirements, such as but not limited to, eating, bathing, dressing, and which care is required primarily due to reasons of age and not reasons of sickness.

36.4(6) "*Accident*" and "*accidental injury*" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause, and occur while the insurance is in force.

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

36.4(7) "*Sickness*" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

36.4(8) "*Preexisting condition*" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment within a five-year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended

by a physician or received from a physician within a five-year period preceding the effective date of the insured person.

36.4(9) *“Physician”* may be defined by including words such as *“duly qualified physician”* or *“duly licensed physician.”* The use of the term “physician” requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.

36.4(10) *“Nurses”* may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words “nurse,” “trained nurse” or “registered nurse” are used without specific definition, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Iowa.

36.4(11) *“Total disability”*.

a. A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience and who is not in fact engaged in any employment or occupation for wage or profit.

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (1) perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of the person’s occupation”; or (2) engage in any training or rehabilitation program.

c. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of the person’s regular occupation or use words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured’s immediate family).

36.4(12) *“Partial disability”* shall be defined in relation to the individual’s inability to perform one or more but not all of the “major,” “important,” or “essential” duties of employment or occupation or may be related to a “percentage” of time worked or to a “specified number of hours” or to “compensation.” Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

36.4(13) *“Residual disability”* shall be defined in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important,” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or another term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

36.4(14) *“Medicare”* shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act,” “as then constituted and any later amendments or substitutes thereof,” or words of similar import.

36.4(15) *“Complications of pregnancy”* shall be defined to include:

a. Conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy; and

b. Nonelective Caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

36.4(16) “*Mental or nervous disorders*” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

36.4(17) “*Short-term limited-duration insurance*” means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total.

This rule is intended to implement Iowa Code section 514D.3.
[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.5(514D) Prohibited policy provisions.

36.5(1) Except as provided in subrule 36.4(7), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix, and tonsils. However, the permissible six months’ exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

36.5(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional with the policyholder.

36.5(3) No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and preexisting condition is not specifically excluded by the terms of the policy.

36.5(4) A disability income policy may contain a “return of premium” or “cash value benefit” so long as:

a. Such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

b. The insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

36.5(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

36.5(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

b. Mental or emotional disorders, alcoholism and drug addiction;

c. Pregnancy, except for complications of pregnancy;

d. Illness or medical condition arising out of:

(1) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; or service in the armed forces or units auxiliary thereto;

(2) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(3) Aviation;

(4) With respect to short-term nonrenewable policies, of less than 12 months in duration, interscholastic sports;

(5) With respect to disability income protection policies, incarceration;

e. Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

h. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law; services performed by a member of the covered person’s immediate family and services for which no charge is normally made in the absence of insurance;

i. Dental care or treatment;

j. Eye glasses, hearing aids and examination for the prescription or fitting thereof;

k. Rest cures, custodial care, transportation and routine physical examinations;

l. Territorial limitations.

36.5(7) The provisions of this chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

36.5(8) Except as otherwise provided in 36.7(1), the terms “Medicare supplement,” “Medigap,” and words of similar import shall not be used unless the policy is issued in compliance with 191—Chapter 37.

36.5(9) Policy provisions precluded in this subrule shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions or coverages in accordance with Iowa Code section 514D.3(2), which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

36.5(10) Rescinded IAB 10/30/91, effective 12/4/91.

191—36.6(514D) Accident and sickness minimum standards for benefits. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subrules. No individual policy of accident and sickness insurance or nonprofit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the commissioner finds that such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in 36.7(12).

Nothing in this rule shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in this chapter.

Nonprofit hospital and medical service associations are subject to this chapter. When such associations are prohibited from issuing subscriber contracts which include all of the benefits required in 36.6(2) or 36.6(5), they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefit required. In such event, the combination of contracts will be considered to have been issued in compliance with this chapter.

36.6(1) General rules.

a. A “noncancelable,” “guaranteed renewable,” or “noncancelable and guaranteed renewable” policy shall not provide for termination of coverage of the spouse solely because of the occurrence of

an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

b. The terms "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 36.7(1)"a." The terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60 the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

c. In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancelable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse, to the age or for the durational period as specified in said definition.

d. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

e. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro-rata basis.

f. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

g. Policies providing skilled, or convalescent, or extended care benefits following hospitalization shall not condition the benefits upon admission to the nursing facility within a period of less than 14 days after discharge from the hospital.

h. Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of the date, the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

i. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

j. A policy may contain a provision relating to recurrent disabilities; provided, however, that no provision shall specify that a recurrent disability be separated by a period greater than six months.

k. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

l. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

m. Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

n. Termination of the policy shall be without prejudice to coverage for any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, or payment of the maximum benefits.

o. Rescinded IAB 11/27/91, effective 1/1/92.

36.6(2) "*Basic hospital expense coverage*" is a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

a. Daily hospital room and board in an amount not less than the lesser of 80 percent of the charges for the semiprivate room accommodations or \$100 per day;

b. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80 percent of the charges incurred up to at least \$3,000 or ten times the daily hospital room and board benefits;

c. Hospital outpatient services consisting of (1) hospital services on the day surgery is performed, and (2) hospital services rendered within 72 hours after accidental injury, in an amount not less than \$150, and (3) X-ray and laboratory tests, to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital in an amount not less than \$100.

Benefits provided under "a" and "b" above may be provided subject to a combined deductible amount not in excess of \$100.

36.6(3) "*Basic medical-surgical expense coverage*" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

a. Surgical services:

(1) In amounts not less than those provided in a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$1,000 for any one procedure; or

(2) Not less than 80 percent of the reasonable charges.

b. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or assistant) performing the surgical services:

(1) In an amount not less than 80 percent of the reasonable charges; or

(2) Fifteen percent of the surgical service benefit.

c. In-hospital medical services, consisting of physician services other than surgical care, rendered to a person who is a bed patient in a hospital for treatment of sickness or injury in an amount not less than 80 percent of the reasonable charges or \$50 per day for not less than 21 days during one period of confinement.

36.6(4) "*Hospital confinement indemnity coverage*" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than

\$40 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

a. Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

b. Except as provided in 191—Chapter 38, division II, benefits shall be paid regardless of other coverage.

36.6(5) *Individual major medical expense coverage.*

a. “Individual major medical expense coverage” is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$500,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed \$10,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 5 percent of the aggregate maximum limit under the policy for each covered person for at least:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care, consisting of physicians’ services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) Not fewer than three of the following additional benefits:

1. In-hospital private duty registered nurse services.

2. Convalescent nursing care.

3. Diagnosis and treatment by a radiologist or physiotherapist.

4. Rental of special medical equipment, as defined by the insurer in the policy.

5. Artificial limbs or eyes, casts, splints, trusses or braces.

6. Treatment for functional nervous disorders, and mental and emotional disorders.

7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(5) “*a*” may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(5) “*a*”(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(6) *Individual basic medical expense coverage.*

a. “Individual basic medical expense coverage” is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$250,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed \$25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per

year basis, or a combination of these bases not to exceed 10 percent of the aggregate maximum limit under the policy for each covered person for at least:

- (1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed upon by the insurer and provider for a period of not less than 31 days during continuous hospital confinement;
- (2) Miscellaneous hospital services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and
- (7) Not fewer than three days of the following additional benefits:
 1. In-hospital private duty registered nurse services;
 2. Convalescent nursing home care;
 3. Diagnosis and treatment by a radiologist or physiotherapist;
 4. Rental of special medical equipment, as defined by the insurer in the policy;
 5. Artificial limbs or eyes, casts, splints, trusses or braces;
 6. Treatment for functional nervous disorders, and mental and emotional disorders; or
 7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(6) "a" may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(6) "a"(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed upon by the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(7) *"Disability income protection coverage"* is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them which:

a. Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

b. Contains an elimination period no greater than:

- (1) Ninety days in the case of a coverage providing a benefit of one year or less;
- (2) One hundred eighty days in the case of coverage providing a benefit of more than one year but not greater than two years; or
- (3) Three hundred sixty-five days in all other cases during the continuance of disability resulting from sickness or injury; and

c. Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy or childbirth in which case the period for disability may be one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period.

If a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

Subrule 36.6(7) does not apply to those policies providing business buy-out coverage.

36.6(8) “*Accident only coverage*” is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

36.6(9) *Specified disease and specified accident coverage.*

a. “Specified disease coverage” is a policy which meets one of the following definitions:

(1) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount, if any, not in excess of \$250 and an overall aggregate benefit limit of not less than \$5,000 and a benefit period of not less than two years for at least the following incurred expenses:

1. Hospital room and board and any other hospital-furnished medical services or supplies;
2. Treatment by a legally qualified physician or surgeon;
3. Private duty services of a registered nurse (R.N.);
4. X-ray, radium and other therapy procedures used in diagnosis and treatment;
5. Professional ambulance for local service to or from a local hospital;
6. Blood transfusions, including expense incurred for blood donors;
7. Drugs and medicines prescribed by a physician;
8. The rental of a respirator or similar mechanical apparatus;
9. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
10. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
11. May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(2) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined in a hospital and a benefit period of not less than 500 days.

b. “Specified accident coverage” is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than \$5,000 for accidental death, \$5,000 for double dismemberment, and \$2,500 for single dismemberment.

36.6(10) “*Limited benefit health insurance coverage*” is any policy or contract which provides benefits that are less than the minimum standards for benefits required under 36.6(2) to 36.6(8). Limited benefit policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by 36.7(12) is completed and delivered as required by 36.7(2). A policy covering a specified disease or combination of diseases shall meet the requirements of 36.6(9) and shall not be offered for sale as a “limited coverage.” A policy which is designed to supplement Medicare shall meet the requirements of 191—Chapter 37 and shall not be offered for sale as a “limited coverage.”

36.6(11) *Short-term limited-duration insurance coverage.*

a. “Short-term limited-duration insurance coverage” provides coverage up to an aggregate maximum of not less than \$500,000 for each initial or renewal policy term and shall include a minimum of all of the following services subject to the approved policy terms, limitations and exclusions:

- (1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;
- (2) Miscellaneous hospital services, including emergency room services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care consisting of physicians’ services rendered on an ambulatory basis, and through telemedicine by remote diagnosis and treatment of patients by means of telecommunications technology, where coverage is not provided elsewhere in the policy for diagnosis and treatment of

sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

- (7) In-hospital registered nurse services;
- (8) Convalescent nursing care;
- (9) Diagnosis and treatment by a radiologist or physiotherapist;
- (10) Rental of special medical equipment, as defined by the insurer in the policy;
- (11) Artificial limbs or eyes, casts, splints, trusses or braces;
- (12) Treatment for functional nervous disorders, mental and emotional disorders and substance use disorders; and
- (13) Out-of-hospital prescription drugs and medications.

b. If the short-term limited-duration insurance coverage establishes a separate out-of-pocket maximum for the prescription drug benefit, the short-term limited-duration insurance coverage shall contain a deductible, coinsurance and copayment out-of-pocket maximum for all benefits for each covered person, excluding prescription drug services, that shall not exceed \$5,000 multiplied by the number of months of coverage and not in excess of \$20,000 for the full policy term of any duration, and the separate prescription drug benefit shall have a deductible, coinsurance and copayment out-of-pocket maximum separate from the other required services that shall not exceed \$2,500 multiplied by the number of months of coverage and not in excess of \$10,000 for the full policy term of any duration.

c. If the short-term limited-duration insurance coverage integrates a prescription drug benefit into the plan design, the deductible, coinsurance and copayment out-of-pocket maximum for each covered person for all medical and prescription drug coverage shall not exceed \$7,500 multiplied by the number of months of coverage and not in excess of \$30,000 for the full policy term of any duration.

d. After 180 days of coverage, short-term limited-duration insurance coverage that has an initial policy term or has been renewed or extended beyond 180 days in duration shall also provide preventative and wellness services subject to deductibles, coinsurance and copayments, including annual routine office visits, immunizations, mammography examinations, prostate-specific antigen blood tests and Papanicolaou tests.

e. Short-term limited-duration insurance shall not contain preexisting condition exclusions that exceed the initial policy term. Any renewable short-term limited-duration insurance shall be guaranteed renewable.

f. Short-term limited-duration insurance shall have an expiration date specified in the policy.

g. All short-term limited-duration policies shall contain the notices required of short-term limited-duration insurance as set forth in the Public Health Service Act, 45 CFR Section 144.103.

h. All short-term limited-duration insurance shall contain a free-look period of not less than ten days after the insured receives the policy during which the insured may cancel the insurance. If the insurance is so canceled, all fees and premiums paid shall be promptly refunded and the insurance shall be voided as if the policy had not been issued. Notice of the free-look period shall be prominently displayed on the first page of the policy.

(1) For the purposes of this paragraph, the policy shall be determined to be received by the insured as follows:

1. Pursuant to Iowa Code section 554D.117 if received electronically; and
2. Four days after the policy is postmarked for delivery if sent in the mail.

(2) For the purposes of this paragraph, the insured may cancel the insurance by giving notice to the insurance company, agent, broker or other representative in any manner, including but not limited to via electronic notice or by telephone.

i. All applications for short-term limited-duration insurance shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and identify any preexisting conditions.

This rule is intended to implement Iowa Code section 514D.4.

[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.7(514D) Required disclosure provisions.

36.7(1) *General rules.*

a. Each individual policy of accident and sickness insurance or hospital, medical, or dental service corporation subscriber contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

b. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

c. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

d. A policy which provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import shall include a definition and explanation of the terms “usual and customary” or “reasonable and customary” in its accompanying outline of coverage.

e. If a policy contains any limitations with respect to preexisting conditions the limitations must appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”

f. All accident only policies shall contain a prominent statement on the first page of the policy or attached to it, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, as follows:

“This is an accident only policy and it does not pay benefits for loss from sickness.”

g. All policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached to it stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

h. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

i. If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege,” or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

j. Insurers issuing policies which provide hospital or medical expense coverage on an expense-incurred or indemnity basis other than incidentally, to a person(s) eligible for Medicare by reason of age, shall provide to the policyholder a Medicare supplement buyer’s guide in the form of the booklet “Guide to Health Insurance for People with Medicare” developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services. Delivery of the buyer’s guide shall be made whether or not the policy qualifies as a “Medicare supplement coverage” in accordance with 191—Chapter 37. Except in the case of direct response insurers, delivery of the buyer’s guide shall be made at the time of application and acknowledgment of receipt of certification of delivery of the buyer’s guide shall be provided to the insurer. Direct response insurers shall deliver the buyer’s guide upon request but not later than at the time the policy is delivered.

k. Outlines of coverage delivered in connection with policies defined in this chapter as Hospital Confinement Indemnity, Specified Disease or Limited Benefit Health Insurance Coverages to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of 36.7(6), 36.7(10) and 36.7(12), the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Medicare Supplement Buyer's Guide, available from the company.

l. If payment will not be made for services performed by a chiropractor acting within the scope of the chiropractor's license when those services would be compensable if performed by a medical doctor, then a statement that services performed by a chiropractor are not compensable shall be included in all outlines of coverage delivered in accordance with this chapter.

m. Disclosure requirements. All insurers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all insurers offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All insurers shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

36.7(2) *Outline of coverage requirements for individual coverages.* No individual accident and sickness insurance policy or nonprofit hospital, medical or dental service corporation subscriber contract subject to this chapter shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in 36.7(3) to 36.7(12), is completed as to the policy or contract and

a. Delivered with the policy; or

b. Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of the outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of 36.6(2) shall be that statement contained in 36.7(3). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(3) shall be the statement contained in 36.7(5). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(5) or 36.6(3) and 36.6(5) or 36.6(2), 36.6(3), and 36.6(5) shall be the statement contained in 36.7(7).

Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical, or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

36.7(3) *Basic hospital expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2). The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

b. Basic hospital expense coverage. Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Hospital outpatient services; and
- (4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(4) *Basic medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of subrule 36.6(3). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

**BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE**

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

b. Basic medical-surgical expense coverage. Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- (1) Surgical services;
- (2) Anesthesia services;
- (3) In-hospital medical services; and
- (4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(5) *Basic hospital and medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2) and 36.6(3) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
 BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
 OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Basic hospital and medical-surgical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Hospital outpatient services;
- (4) Surgical services;
- (5) Anesthesia services;
- (6) In-hospital medical services; and
- (7) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(6) *Hospital confinement indemnity coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(4). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
 HOSPITAL CONFINEMENT INDEMNITY COVERAGE
 OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Hospital confinement indemnity coverage. Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. These policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

c. (A brief specific description of the benefits contained in this policy, in the following order:

- (1) Daily benefit payable during hospital confinement; and
- (2) Duration of benefit described in “c”(1).)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

f. (Any benefits provided in addition to the daily hospital benefit.)

36.7(7) Major medical expense coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(5) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Major medical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care;
- (7) Maximum dollar amount for covered charges; and
- (8) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(8) Disability income protection coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(6) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Disability income protection coverage. Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(9) *Accident only coverage (outline of coverage)*. An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(7). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Accident only coverage. Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1) "m.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(10) *Specified disease or specified accident coverage (outline of coverage)*. An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(8). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. (Specified disease) (Specified accident) coverage. Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1) "m.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation or right to change premiums.)

36.7(11) *Medicare supplement coverage (outline of coverage)*. Rescinded IAB 10/30/91, effective 12/4/91.

36.7(12) *Limited benefit health coverage (outline of coverage)*. An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards

of subrules 36.6(2) to 36.6(8). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Limited benefit health coverage. Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)
(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subrule 36.6(1) "n.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 36.7(12) "c.")

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(13) Short-term limited-duration insurance coverage.

a. Outline of coverage. An outline of coverage, in the form prescribed below, shall be issued in connection with any short-term limited-duration insurance, as set forth in subrule 36.6(11). This outline of coverage must be provided in addition to the notices required by paragraph 36.6(11) "g." The items included in the outline of coverage must appear in the sequence prescribed below, and Section A must be in at least 14-point type or, if electronic, of equivalent prominence:

[COMPANY NAME]
SHORT-TERM LIMITED-DURATION INSURANCE COVERAGE
OUTLINE OF COVERAGE

[If coverage begins before January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PREEXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOSPITALIZATION, EMERGENCY SERVICES, MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. ALSO, THIS COVERAGE IS NOT "MINIMUM ESSENTIAL COVERAGE" FOR ANY MONTH IN 2018. YOU MAY HAVE TO MAKE A PAYMENT WHEN YOU FILE YOUR TAX RETURN UNLESS YOU QUALIFY FOR AN EXEMPTION FROM THE REQUIREMENT THAT YOU HAVE HEALTH COVERAGE FOR THAT MONTH.

[If coverage begins on or after January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PREEXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOSPITALIZATION,

EMERGENCY SERVICES, MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

B. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

C. [A brief specific description of the benefits, including dollar amounts, contained in this policy. The description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment or other out-of-pocket cost provisions applicable to the benefits described. The description of benefits shall also clearly state any applicable provider network requirements including but not limited to distinctions in cost provisions for in-network and out-of-network providers.]

D. [A description of any other policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Section C, above, including but not limited to any preexisting condition exclusions for policies.]

E. [A description of policy provisions regarding renewability or continuation of coverage, including any reservation of right to change premiums.]

b. Application for coverage for short-term limited-duration insurance. All applications for short-term limited-duration policies shall contain the notice prescribed below, which shall be in at least 14-point type or, if electronic, of equivalent prominence. One signed copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

STATEMENT TO APPLICANT BY ISSUER [PRODUCER, BROKER OR OTHER REPRESENTATIVE]:

Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under this policy. This could result in a denial or delay of payment of benefits. If you wish to purchase a short-term limited-duration policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ALSO NOTE THAT, IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

(Signature of Producer, Broker or Other Representative of the Company)
[Typed Name and Address of Producer, Broker or Other Representative]

The above "Statement to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)
[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.8(507B) Requirements for replacement.

36.8(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

36.8(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in 36.8(3). One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in 36.8(4). In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

36.8(3) The notice required by 36.8(2) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

36.8(4) The notice required by subrule 36.8(2) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

c. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

191—36.9(514D) Filing requirements.

36.9(1) *Rate filing.* Every policy, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in a rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement shall also be filed.

36.9(2) *Contents of rate filings.* Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called “anticipated creditable loss ratio,” of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of these present values only if it is a significant factor in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary’s knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of Iowa and that the benefits are reasonable in relation to premiums.

36.9(3) *Previously approved forms.* Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

a. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form.

b. A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefor.

c. A history of the experience under existing rates, including at least the data indicated in 36.9(4). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim runoffs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves

for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.

d. The date and magnitude of each previous rate change, if any.

36.9(4) Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the accident and health policy experience exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

36.9(5) Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

a. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.

b. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.

c. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.

d. The mix of business by risk classification.

191—36.10(514D) Loss ratios.

36.10(1) Average annual premium.

a. New forms. With respect to a new form under which the average annual premium (as defined below) is expected to be at least \$200 benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

| Type of Coverage | Renewal Clause | | | | |
|--------------------------|----------------|-----------|-----------|-----------|--|
| | <u>OR</u> | <u>CR</u> | <u>GR</u> | <u>NC</u> | |
| Medical Expense | 60% | 55% | 55% | 50% | |
| Loss of Income and other | 60% | 55% | 50% | 45% | |

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is \$100 or more but less than \$200, subtract five percentage points from the numbers in the table above, or if less than \$100, subtract ten percentage points.

b. The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The above anticipated loss ratio standards do not apply to a class of business where such standards are in conflict with specific statutes or regulations.

c. Definitions of renewal clause.

OR—Optionally Renewable: Renewal is at the option of the insurance company.

CR—Conditionally Renewable: Renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR—Guaranteed Renewable: Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC—Non-Cancelable: Renewal cannot be declined nor can rates be revised by the insurance company.

36.10(2) Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided the following standards are met.

a. With respect to forms issued on and after the effective date of the revision, the standards are the same as in 36.10(1) above, except that the average annual premium shall be determined based on an actual rather than an anticipated distribution of business.

b. With respect to forms issued prior to the effective date of the revision, both (1) and (2) as follows shall be at least as great as the standards in 36.10(1):

(1) The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

(2) The ratio of (i) and (ii); where

(i) Is the sum of the accumulated benefits, from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision, and the present value of future benefits, and

(ii) Is the sum of the accumulated premiums from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

36.10(3) Credibility factors. Anticipated loss ratios different than those indicated in 36.10(1) and 36.10(2) will require justification based on the special circumstances that may be applicable.

a. Examples of coverages requiring special consideration are as follows:

- (1) Accident only;
- (2) Short term nonrenewable, e.g., airline trip, student accident;
- (3) Specified peril, e.g., cancer, common carrier;
- (4) Other special risks.

b. Examples of other factors requiring special consideration are as follows:

- (1) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
- (2) Extraordinary expenses;
- (3) High risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;
- (4) Product features such as long elimination periods, high deductibles and high maximum limits;
- (5) The industrial or debit method of distribution;
- (6) Forms issued prior to the effective date of these guidelines.

Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

36.10(4) Medicare supplement policies. Rescinded IAB 10/30/91, effective 12/4/91.

191—36.11(514D) Certification. Any policy form submitted to the insurance division for approval which is subject to Iowa Code chapter 514D shall be in conformance with the applicable requirements of Iowa Code chapter 514D and with the filing requirements set forth in rule 191—20.1(505,509,514A,515,515A,515F).

191—36.12(514D) Severability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

191—36.13(513C,514D) Individual health insurance coverage for children under the age of 19.

36.13(1) Purpose, applicability and effective date.

a. The purpose of this rule is to set forth the requirements and procedures to be followed for individual health insurance coverage for children under the age of 19.

b. This rule shall apply to all “carriers” as defined in Iowa Code subsection 513C.3(5). For purposes of this rule, “carrier” means the same as it is defined in Iowa Code subsection 513C.3(5).

c. For purposes of this rule, a “child-only” policy means a health benefit plan delivered or issued for delivery to an individual who is the primary subscriber on the policy and who is under the age of 19. A “child-only” policy does not include a health benefit plan that is delivered or issued for delivery to a primary subscriber who is 19 years of age and older but that insures persons under the age of 19.

d. This rule shall become effective June 8, 2011, for policies sold or issued on or after that date.

36.13(2) Coverage requirement for children under the age of 19, open enrollment period and notice.

a. Carriers doing business in the state of Iowa shall offer coverage to primary subscribers under the age of 19 during the open enrollment period as established in this rule.

b. The open enrollment period for child-only policy applicants shall commence on July 1, 2011, and end on August 14, 2011. Carriers shall provide subsequent open enrollment periods for child-only policy applicants for the periods of July 1 through August 14 in the years 2012 and 2013.

c. A carrier shall advertise the open enrollment period for children under the age of 19, including the availability of child-only policy coverage, on the carrier’s website and through any other media as determined by the carrier. The advertising shall be conspicuous and provided in a manner reasonably calculated to give potential applicants timely and informative notice regarding the annual open enrollment period.

d. For child-only policy applications received during the open enrollment period, individual health insurance coverage shall be offered on a guaranteed-issue basis to individuals under the age of 19. The child-only policies shall be in compliance with federal and state law and shall be filed with the Iowa insurance division in accordance with Iowa law.

e. Carriers are not required to offer child-only policies outside the open enrollment periods provided in this subrule. However, a carrier shall permit a child under the age of 19 to apply and enroll for child-only policy coverage during a special enrollment period under the terms of the child-only policy if the child has experienced a qualifying event. A child-only policy issued during a special enrollment period after a qualifying event shall be issued on a guaranteed basis and shall not impose any preexisting conditions. For purposes of this paragraph, a “qualifying event” shall mean one or more of the following:

(1) The child lost creditable coverage as defined in Iowa Code section 514A.3B(3) as a result of termination of the parent’s or guardian’s employment or eligibility, the involuntary termination of the creditable coverage, death of the child’s parent or guardian, or the divorce or legal separation of the child’s parent or guardian, and a request for special enrollment is made within 30 days after termination of the creditable coverage.

(2) The child became a resident of Iowa during a month that was not the child’s birth month, and a request for coverage is made within 30 days after the child became a resident of Iowa.

(3) An event of marriage, birth, adoption or placement for adoption occurs and the request for special enrollment is made within 30 days after the occurrence of the event.

(4) The child was covered under a mandated continuation of a group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

(5) A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered parent’s or guardian’s health insurance coverage and the request for enrollment is made within 30 days after issuance of the court order.

(6) The child changes status and the parent or guardian becomes an eligible employee and requests enrollment within 63 days after the date of the change in status.

f. An individual applying for coverage during the open enrollment period or during a special enrollment period shall not be eligible for guaranteed-issue coverage if the individual has other coverage or if other coverage is available at the time of the effective date of coverage. Other coverage shall not include coverage through the Iowa Comprehensive Health Association (HIPIOWA) or HIPIOWA-FED.

g. A carrier that issues a policy pursuant to this rule shall comply with all other applicable statutes and administrative rules, both state and federal, regarding individual health benefit policies.

h. A child-only policy may be appropriately rated based on the health status of the child-only policy applicant.

[ARC 9498B, IAB 5/4/11, effective 6/8/11]

191—36.14 to 36.19 Reserved.

These rules are intended to implement Iowa Code chapters 507B, 510, 513C and 514D.

DIVISION II
RATE HEARINGS

191—36.20(514D,83GA,SF2201) Rate hearings.

36.20(1) Purpose, applicability and effective date.

a. *Purpose.* The purpose of this rule is to set forth a procedure to be followed for hearings about certain health insurance policy premium rate increases.

b. *Applicability.* This rule applies to all individual health insurance policies issued or to be issued in Iowa except those excluded by 2010 Iowa Acts, Senate File 2201, section 8(4A).

c. *Effective date.* This rule became effective October 1, 2010.

36.20(2) Definitions.

“Carrier” shall mean a health insurance carrier licensed to do business in the state as used in 2010 Iowa Acts, Senate File 2201, section 8.

“Commissioner” shall mean the Iowa insurance commissioner or designee.

“Consumer advocate” shall mean the division’s consumer advocate described by Iowa Code section 505.8(6) or designee.

“Division” shall mean the Iowa insurance division.

“Filing” shall mean a rate filing presented to the division for approval pursuant to this chapter, Iowa Code chapter 514D and 2010 Iowa Acts, Senate File 2201, through the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing.

“Health insurance” shall mean the same as “health insurance” is used in 2010 Iowa Acts, Senate File 2201, section 8, and excludes the types of insurance listed in 2010 Iowa Acts, Senate File 2201, section 8(4A).

“Hearing” shall mean a public hearing for purposes of accepting comments regarding a premium rate increase for which a carrier has requested approval from the commissioner. The hearing is for the gathering of comments; it is not an adjudicatory proceeding or an administrative action.

“Plan” shall mean the policy form(s) subject to the rate change proposal.

“Rate” shall mean the premiums (or premium rates) presented to the division for approval.

36.20(3) Filing and notice required. Carriers that are required to file an application for a rate increase shall make a filing according to division procedures through the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing. When a carrier makes a request for the commissioner’s approval of a rate filing and the requested rate in the application is for a rate increase exceeding the average annual health spending growth rate stated in the most recent National Health Expenditure projection published by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services:

a. The carrier shall contact the division to obtain a hearing date, time and location.

b. Once the hearing is scheduled with the division, the carrier shall provide a notice of the intended rate increase and of the date, time and location of the rate hearing at least 45 days before the hearing.

c. The notice shall be in writing and shall be mailed to all persons insured by the plan for which the carrier is requesting approval of the rate increase.

d. The notice shall specify the proposed rate increase that is applicable to each policyholder and shall include the ranking and quantification of those factors that are responsible for the amount of the rate increase proposed.

e. The notice shall include information about how the policyholder can contact the consumer advocate for assistance.

f. The notice shall state the following:

NOTICE OF PROPOSED PREMIUM INCREASE

Dear [INSURED]

[CARRIER] has asked the Iowa Insurance Division to approve an increase in premium rates of approximately []% with a proposed effective date of [DATE].

For your policy, the increase is anticipated to be as follows:

[CURRENT MONTHLY RATE] + [PROPOSED INCREASE] = [PROPOSED MONTHLY RATE]

Your actual premium increase may be less or greater than the proposed average premium increase due to a variety of factors that are independent of the proposed premium rate increase, including but not limited to age, geographic area, and plan design. In addition, the final rate you receive may be different than that listed above due to changes in those factors while the rate is pending approval or due to input from the Iowa Insurance Commissioner.

[RANKING AND QUANTIFICATION OF THOSE FACTORS THAT ARE RESPONSIBLE FOR THE AMOUNT OF THE RATE INCREASE PROPOSED]

A public hearing will be held at [TIME], [DATE], at [LOCATION] before the Iowa Insurance Commissioner to receive comments from [CARRIER] and the Iowa Insurance Consumer Advocate on the proposed rate increase.

You may contact the Consumer Advocate for assistance or to comment on the proposed premium rate at:

Iowa Insurance Division Consumer Advocate
 Iowa Insurance Division
 Two Ruan Center
 601 Locust Street, Fourth Floor
 Des Moines, Iowa 50309
 Telephone: (515)281-5705
 Iowa-toll free: 1-877-955-1212
 Fax: (515)281-3059
 E-mail: consumer.advocate@iid.iowa.gov

All comments received will be considered public records. The Consumer Advocate will post comments received on the division's website at www.iid.iowa.gov, and the Consumer Advocate will present the comments at the public hearing.

g. If an insurer wishes to use language in its notice that is different from the language in paragraph "*f.*" it must seek the approval of the commissioner prior to using different language. The request for approval shall be submitted to the commissioner via the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing.

36.20(4) Comments.

a. The consumer advocate shall collect any public testimony or comments received from policyholders regarding the rate increase request.

b. The consumer advocate shall post without delay all comments received on the division's website.

c. The consumer advocate shall provide the comments to the commissioner and present them at the hearing.

36.20(5) Evidence requested by the commissioner. At any time after the filing of the request for approval of the rate increase, the commissioner may:

a. Request additional information from the carrier, and the carrier shall furnish any additional information as requested;

b. Request the submission of additional information by any other party to the filing; and

c. Obtain independent analysis of the filing by qualified experts as permitted under Iowa Code section 505.15.

36.20(6) Hearing.

- a. The hearing shall be open to the public.
- b. The division shall make a record of the hearing. The cost of making the record shall be paid by the carrier. The cost of copies of the record requested by the carrier or by the division shall also be paid by the carrier.
- c. At the hearing, the carrier that is requesting the commissioner's approval of the rate increase may present testimony and information to support its position in addition to the information supplied with the filing. The costs of the carrier's presentation shall be paid by the carrier.
- d. The consumer advocate shall present at the hearing the public testimony and comments received.
- e. Formal rules of pleading or evidence need not be observed at any hearing.
- f. The hearing does not constitute a contested case under Iowa Code chapter 17A.

36.20(7) Confidentiality. Information submitted to the division as part of a filing and as part of the hearing process shall constitute a public record under Iowa Code chapter 22 except as provided in Iowa Code section 505.17 and 2010 Iowa Acts, Senate File 2201, section 6.

36.20(8) Record of expenses. A carrier shall maintain a record of expenses incurred by the carrier in relation to any rate hearing and shall submit it to the commissioner within 30 days following the date of the rate hearing.

36.20(9) Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

[ARC 9158B, IAB 10/20/10, effective 10/1/10; ARC 4780C, IAB 11/20/19, effective 12/25/19]

This rule is intended to implement Iowa Code chapter 514D and 2010 Iowa Acts, Senate File 2201.

[Filed 11/5/81, Notice 9/2/81—published 11/25/81, effective 12/31/81]¹

[Filed emergency 2/26/82—published 3/17/82, effective 3/11/82]

[Filed 5/7/82, Notice 3/17/82—published 5/26/82, effective 7/1/82]

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[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]

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[Filed Emergency After Notice ARC 4332C (Notice ARC 4242C, IAB 1/16/19), IAB 3/13/19, effective 2/20/19]

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

¹ Effective date of 12/31/81 delayed 70 days by Administrative Rules Review Committee.

² See IAB Insurance Division