

CHAPTER 35  
ACCIDENT AND HEALTH INSURANCE

BLANKET ACCIDENT AND SICKNESS INSURANCE  
[Prior to 10/22/86, Insurance Department[510]]

**191—35.1(509) Purpose.** The purpose of this regulation is to establish guidelines for insurers to make special risk coverage available to particular groups that will be exposed to specific hazards for a certain period of time.

**191—35.2(509) Scope.** These rules shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

**191—35.3(509) Definitions.**

**35.3(1)** Blanket accident and sickness insurance is hereby declared to be that form of accident, sickness or accident and sickness insurance designed to insure against specified hazards incident to or defined by reference to a particular activity or activities and covering groups of persons as enumerated in the following subparagraphs:

*a.* Under a policy issued to an employer, who shall be deemed the policyholder covering any group of employees defined by reference to specific hazards incident to an activity or activities of the policyholder.

*b.* Under a policy issued to a college, high school, junior high school, grade school, school district, school jurisdictional unit or other institution of learning; or to the head, principal, governing board of any such educational unit who or which shall be deemed the policyholder covering students, teachers or employees.

*c.* Under a policy issued to any religious, charitable or educational organization, or branch thereof, which shall be deemed the policyholder covering any group of members or participants defined by reference to specified hazards incident to an activity or activities sponsored or supervised by such policyholder.

*d.* Under a policy issued to a sports team, youth camp, recreational organization or sponsor thereof, which shall be deemed the policyholder, covering members, campers, participants, employees, officials or supervisors.

*e.* Under a policy issued to any volunteer fire department, first aid, civil defense or other such volunteer organizations, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

*f.* Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

*g.* Under a policy issued to an association, other than a labor union, trade association or industrial association, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

*h.* Under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

**35.3(2)** Brochure shall mean an instrument, booklet or pamphlet setting forth a statement as to the insurance protection provided, to whom the insurance benefits are payable, sufficient information on the procedure an insured shall follow in filing a claim and such other provisions as are in the opinion of the commissioner of insurance necessary to inform the holder thereof as to rights under the policy.

**191—35.4(509) Required provisions.** No blanket policy as herein defined shall be issued or delivered in this state unless a copy of the policy and brochure if required, has been approved by the commissioner

of insurance in accordance with the provisions set forth in rule 35.7(509). All policies of blanket accident or sickness insurance or combination thereof issued in this state shall contain in substance the following provisions:

**35.4(1)** A provision that the policy including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense of a claim under the policy, unless it is contained in a written application. If a copy of such application is not delivered to the person insured the insurer shall be precluded from introducing such application as evidence in any action involving any statements contained therein.

**35.4(2)** A provision that written notice of sickness or of injury must be given to the insurer within 20 days of the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

**35.4(3)** A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after giving such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**35.4(4)** A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

**35.4(5)** A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

**35.4(6)** A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

**35.4(7)** A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**191—35.5(509) Application and certificates not required.** An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate; however, a brochure as herein defined shall be issued to the policyholder for delivery to each person insured as defined in 35.3(1)“b” and “g.”

**191—35.6(509) Facility of payment.** All benefits under any blanket accident and sickness policy shall be payable to the person insured, to a designated beneficiary or beneficiaries, or to their estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to their parent, guardian or other person actually supporting the insured, designated beneficiary, or beneficiaries. The policy may also provide that all or a portion of any indemnities provided

by any such policy on account of hospital, nursing, medical or surgical services may with the consent of the insured be paid directly to the hospital or person rendering such services, but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid.

These rules are intended to implement Iowa Code section 509.6.

**191—35.7(509) General filing requirements.**

**35.7(1)** All filings submitted to the Iowa division of insurance must be accompanied by a prepaid self-addressed envelope large enough to contain all copies of material requested to be returned.

**35.7(2)** All filings must be accompanied by a cover letter in duplicate which gives the form numbers, titles, effective date of the filing and a brief identifying description of the forms submitted. If the filing amends or changes a prior filing, the previous provisions and new provisions should be described in the cover letter with an explanation for the changes. The date of home state approval or acknowledgment should be included in the cover letter. Home state approval is a prerequisite to review by the division unless the form will not be used in the state of domicile. Any differences between the filing submitted to Iowa and the filing approved in the domiciliary state should be explained.

**35.7(3)** A copy of each form for which approval is requested shall be transmitted with the filing. If the forms submitted refer to both life and accident and health coverages, the cover letter must be submitted in triplicate with two copies of each form for which approval is requested.

**35.7(4)** Each filing submitted to the insurance division for approval shall conform to the applicable requirements of Iowa Code chapter 509 and shall be accompanied by a certification of the general counsel or an officer of the submitting company that to the best of their knowledge and belief the policy form is in compliance with the insurance laws of Iowa and these rules.

**35.7(5)** Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

**35.7(6)** Any insured or established organization with one or more insureds among its members may file a written request with the commissioner for a hearing on a proposed form filing. A request for hearing must be filed within 20 days of receipt of the form filing by the commissioner.

**35.7(7)** The commissioner of insurance will hold the hearing within 20 days after receipt of the written demand for a hearing and will give not less than 10 days' written notice of the time and place of the hearing to the person or association filing the demand, to the filing insurer or organization, and to any other person requesting notice. The commissioner of insurance may suspend or postpone the effective date of the proposed filing pending such hearing.

**191—35.8 to 35.19** Reserved.

**191—35.20(509A) Life and health self-funded plans.**

**35.20(1) Scope.** This rule applies to life and accident and health self-funded plans for the state of Iowa, political subdivisions of the state, school corporations, and all other public bodies in the state.

**35.20(2) Minimum plan standards.** Self-funded life plans subject to this rule shall meet the requirements of Iowa Code sections 509.1, 509.2, 509.4, and 509.15 and rules thereunder. Self-funded accident and health plans subject to this rule shall meet the requirements of Iowa Code sections 509.1 and 509.3 and rules thereunder.

In order to assure that a self-funded life or health plan is able to cover all reasonably anticipated expenses and to avoid liability for the public body, a self-funded health or life plan shall provide that:

*a.* An annual report showing the starting and ending balance of the fund, deposits of monthly accrual rates and other assets of the fund, and the amount and nature of all disbursements from the fund shall be prepared and submitted to the governing body of the public body. An annual report shall be made to show a separate accounting to reflect all required reserves.

*b.* Monthly accrual rates shall be established at a satisfactory level to provide funds to cover all claims, reserves, and expenses to operate the plan. Accrual rates shall be reevaluated annually. Accrual

rates shall be funded solely through public body contributions or through a combination of employer and employee contributions.

*c.* A plan fund shall be established exclusively for the deposit of monthly accrual rates and other assets pertaining to the plan. After a self-funded health or life plan is established and as long as any claims may be made against the plan fund, all contributions shall be deposited as collected in the plan fund. The plan fund shall be disbursed only for plan expenses.

*d.* The following reserves shall be established in the plan fund:

(1) A reserve for claims that have been incurred by participants under the plan, but have not yet been presented for payment. The appropriate amount of this reserve shall be on an actuarially sound basis as determined by an independent actuary, an insurance company, or a nonprofit health service corporation authorized pursuant to chapter 514.

(2) A claims fluctuation reserve for setting aside funds that become available during a month when claims are less than projected for that month. Funds shall be maintained and available for a month where claims exceed those projected for that month.

*e.* The public body shall obtain a fidelity bond as a guaranty of faithful operation of the self-funded plan by the public body, its officers, agents, and employees.

*f.* Disbursements from the plan fund shall be made only for the following specified plan expenses:

(1) Payment of claims.

(2) Cost of aggregate excess loss coverage.

(3) Cost of specific excess loss coverage.

(4) Bonding expenses.

(5) Payment of service fees applicable to plan design, payment of claims, materials explaining plan benefits, actuarial assistance, legal assistance, and accounting assistance.

(6) Other expenses directly related to the operation of the plan.

*g.* Aggregate excess loss coverage shall be obtained which will limit a public body's total claim liability for each year to not more than 125 percent of the level of claims liability as projected by an independent actuary or insurance company. A public body shall fund this potential additional liability of 25 percent by either allocating necessary funds from the operating fund of the general fund or by setting up an additional reserve in the operating fund. Specific excess loss coverage may also be obtained if a public body wishes to limit its total annual liability on claims for any one claimant.

**35.20(3) *Plan shortfalls.*** If the resources of any self-funded plan subject to this rule are not adequate to fully cover all claims under that plan, then the public body sponsoring that plan shall make up the shortfall from other resources.

**35.20(4) *Confidentiality.*** Information held by the plan administrator of a self-funded plan shall be kept confidential. An employee or agent of the plan administrator shall not use or disclose any information to any person, except to the extent necessary to administer claims or as otherwise authorized by law.

### **191—35.21(509) Review of certificates issued under group policies.**

**35.21(1) *Nondiscretionary groups.*** A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state.

**35.21(2) *Discretionary groups.*** A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group not substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state and if the policy is issued or offered in a state which has reviewed and approved the policy under a statute substantially similar to Iowa Code section 509.1(8).

These rules are intended to implement Iowa Code sections 509.1, 509.6, and 509A.14.

### **191—35.22(509) Group health insurance coverage policy requirements.**

**35.22(1)** A group health insurance coverage shall be renewable except for the following reasons:



of a preexisting condition exclusion. Waiting or affiliation periods shall run concurrently with any applicable preexisting condition exclusion period.

*c.* For purposes of this subrule, “creditable coverage” means health benefits or coverage provided to an individual under any of the following:

- (1) A group health plan as defined in 1997 Iowa Acts, House File 701, section 5.
- (2) Health insurance coverage.
- (3) Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
- (4) Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.
- (5) 10 U.S.C. ch. 55.
- (6) A health or medical care program provided through the Indian health service or a tribal organization.
- (7) A state health benefits risk pool.
- (8) A health plan offered under 5 U.S.C. ch. 89.
- (9) A public health plan as defined under federal regulations.
- (10) A health benefit plan under Section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).
- (11) An organized delivery system licensed by the director of public health.

*d.* A carrier, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

- (1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.
- (2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.
- (3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

*e.* A carrier offering group health insurance coverage shall not impose any preexisting condition as follows:

- (1) In the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.
- (2) In the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.
- (3) Relating to pregnancy as preexisting condition.

*f.* A carrier shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this paragraph “affiliation period” means a period of time not to exceed 60 days for new entrants and not to exceed 90 days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors. This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health insurance coverage, provided that any carrier imposed waiting period is no longer than 60 days and is used in lieu of a preexisting condition exclusion.

g. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed 18 months.

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<sup>1</sup> See IAB Insurance Division