191—75.10(513C) Basic health benefit plan and standard health benefit plan policy forms.

75.10(1) The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in the rules and table.

75.10(2) Termination of pregnancy is to be covered when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard plan.

75.10(3) A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license.

75.10(4) Prescription oral contraceptives and contraceptive devices that are approved by the United States Food and Drug Administration are to be covered in both policy forms.

75.10(5) The division of insurance and the department of health have available "safe harbor" policy forms for the basic and standard health benefit plans required pursuant to Iowa Code chapter 513C.

Iowa Individual Products

Hospital Services	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient Outpatient	60%	80%	80%	60%	60% $400/admit	80% $200/admit
Prostheses	60%	80%	80%	60%	60%	80%
DME—including medical supplies	60%	80%	80%	60%	60%	80%
Ambulance—Emergency	60%	80%	80%	60%	60%	80%
Hospice	60%	80%	80%	60%	60%	80%
Home Health and Physician House Calls	60%	80%	80%	60%	60%	80%

Alcoholism Substance Abuse	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1)	60%(1)	—	80% ($50 max. eligible fee)

Mental Health	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1) ($50 max. eligible fee)	60%(1) ($50 max. eligible fee)	—	80% ($50 max. eligible fee)

(1)$50,000 Lifetime Max.

Iowa Individual Products

General	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Calendar year deductibles (S/F)	$1,500 x 3	$1,000 x 3	$1,000 x 3	$1,000 x 3	—	—

General	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
E.R. Copayment	—	—	—	—	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	80%	60%	60%	80%
Annual out-of-pocket max.[1]	$4,800/ $14,400	$2,000/ $4,000	$2,000/ $4,000	$3,000/ $6,000	$4,000/ $8,000	$2,000/ $4,000
Lifetime Maximum	$250,000	$1,000,000	$1,000,000	$1,000,000	$250,000	$1,000,000
Pre-existing	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)
Rx	60%	80%	80%	60%	Copayment of > $30 or 25%	Copayment of > $20 or 25%
Transplants	None	80%	80%	80%	None	80%

[1]Excludes deductibles and copays

Physician Services	MANDATED INDEMNITY				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Office visits including wellness	60%	80%	$20 copay 100%	$40 copay 60%	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	80%	60%	60%	80%
Inpatient	60%	80%	80%	60%	60%	80%
Outpatient	60%	80%	80%	60%	60%	80%

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

75.10(6) Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions;
7. For any illness or injury suffered as a result of any act of war, declared or undeclared, or military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;
9. For which no expense is incurred;
10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;
11. Rendered by a provider that is a member of the insured's immediate family;
12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;

13. Incurred after the date of termination of the insured's coverage;

14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;

16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;

17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;

18. For custodial care, domiciliary care or rest cures;

19. For treatment in a facility, or part of a facility, that is mainly a place for:

- Rest;
- Convalescence;
- Custodial care;
- Aged;
- Care or treatment of alcoholism or drug addiction;
- Rehabilitation; or
- Training, schooling or occupational therapy;

20. For screening examinations including X-ray examinations made without film;

21. For sterilization or reversal of sterilizations, or both;

22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;

23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;

24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);

25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;

26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;

28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;

29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;

30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;

31. For travel whether or not recommended by a physician;

32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;

33. For maternity care except for complications of pregnancy which is covered as any other illness;

34. For services to the extent that those services are covered by Medicare;

35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);

36. For or related to the transplantation of animal or artificial organs or tissues;

37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;

38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;

39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;

40. For the purchase of wigs or cranial prosthesis;

41. For weekend admission charges, except for emergencies;

42. For orthomolecular therapy including nutrients, vitamins and food supplements;

43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

[**ARC 3682C**, IAB 3/14/18, effective 4/18/18]