

CHAPTER 514C

SPECIAL HEALTH AND ACCIDENT INSURANCE COVERAGES

Referred to in §87.4, §296.7, §331.301, §364.4, §505.28, §505.29, §507A.4, §669.14, §670.7

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514C.1 Supplemental coverage for adopted or newly born children.

1. Any policy of individual or group accident and sickness insurance providing coverage on an expense incurred basis, and any individual or group hospital or medical service contracts issued pursuant to [chapters 509, 514, and 514A](#), which provide coverage for a family member of the insured or subscriber shall also provide that the health insurance benefits applicable for children shall, subject to the enrollment requirements of [this section](#), be payable with respect to a newly born child of the insured or subscriber from the moment of birth, or, in the situation of a newly adopted child of a covered person, such child shall be covered from the earlier of any of the following:

a. The date of placement of the child for the purpose of adoption and continuing in the same manner as for other dependents of the covered person, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

b. The date of entry of an order granting the covered person custody of the child for purposes of adoption.

c. The effective date of adoption.

2. The coverage for adopted or newly born children shall consist of coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and is not subject to any preexisting condition exclusion.

3. If payment of a specific premium or subscription fee is required to provide coverage for a newly born child, the policy or contract may require that notification of birth of a newly

born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within sixty days after the date of birth.

4. If payment of a specific premium or subscription fee is not required to provide coverage for a newly born child, the policy or contract may require that notification of birth of a newly born child must be furnished to the insurer or nonprofit service or indemnity corporation within sixty days after the date of birth in order for coverage to be provided for the child from the date of birth.

5. a. If payment of a specific premium or subscription fee is required to provide coverage for a newly adopted child or child placed for adoption, the policy or contract may require that notification of the adoption or placement for adoption and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within sixty days after the coverage is required to begin under [this section](#).

b. If payment of a specific premium or subscription fee is not required to provide coverage for a newly adopted child or child placed for adoption, the policy or contract may require that notification of the adoption or placement for adoption must be furnished to the insurer or nonprofit service or indemnity corporation within sixty days after the coverage is required to begin under [this section](#).

c. If a covered person fails to provide the required notice or to make payment of premium or subscription fees within the sixty-day period required in [this subsection](#), the newly adopted child or child placed for adoption shall be treated no less favorably by a health carrier than other dependents of the covered person, other than newly born children, who seek coverage under a policy or contract at a time other than the time when the dependent is first eligible to apply for coverage.

[C75, 77, 79, 81, §514C.1]

[2006 Acts, ch 1117, §62](#)

Referred to in [§514E.7](#)

514C.2 Skilled nursing care covered in hospitals.

An insurer, a hospital service corporation, or a medical service corporation, which covers the costs of skilled nursing care under an individual or group policy of accident and health insurance regulated under [chapter 509](#) or [514A](#), a nonprofit hospital or medical and surgical service plan regulated under [chapter 514](#), or a health care service contract regulated under [chapter 514B](#), shall also cover the costs of skilled nursing care in a hospital if the level of care needed by the insured or subscriber has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the hospital or in another hospital or health care facility within a thirty-mile radius of the hospital. The insurer or corporation shall reimburse the insured or subscriber based on the skilled nursing care rate.

[84 Acts, ch 1034, §1](#); [95 Acts, ch 185, §12](#)

514C.3 Dentist's services under accident and sickness insurance policies.

A policy of accident and sickness insurance issued in this state which provides payment or reimbursement for any service which is within the lawful scope of practice of a licensed dentist shall provide benefits for the service whether the service is performed by a licensed physician or a licensed dentist. As used in [this section](#), "licensed physician" includes persons licensed under [chapter 148](#), and "policy of accident and sickness insurance" includes individual policies or contracts issued pursuant to [chapter 514](#), [514A](#), or [514B](#), and group policies as defined in [section 509B.1, subsection 3](#).

[88 Acts, ch 1127, §1](#); [2006 Acts, ch 1117, §63](#); [2008 Acts, ch 1088, §129](#)

514C.3A Disclosures relating to dental coverage reimbursement rates.

1. An individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#), and delivered, amended, or renewed on or after July 1, 1995, that provides dental care benefits with a base payment for those benefits determined upon a usual and customary fee charged by licensed dentists, shall disclose all of the following:

- a. The frequency of the determination of the usual and customary fee.
 - b. A general description of the methodology used to determine usual and customary fees, including geographic considerations.
 - c. The percentile that determines the maximum benefit that the insurer or nonprofit health service corporation will pay for any dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees.
2. The disclosure shall be provided upon request to all group and individual policyholders and subscribers. All proposals for dental care benefits shall inform the prospective policyholder or subscriber that information regarding usual and customary fee determinations is available from the insurer or nonprofit health service corporation. All employee benefit descriptions or supplemental documents shall notify the employee that information regarding reimbursement rates is available from the employer.

95 Acts, ch 78, §1; 95 Acts, ch 209, §26

514C.3B Dental coverage — fee schedules.

1. A contract between a dental plan and a dentist for the provision of services to covered individuals under the plan shall not require that a dentist provide services to those covered individuals at a fee set by the dental plan unless such services are covered services under the dental plan.
2. A person or entity providing third-party administrator services shall not make available any dentists in its dentist network to a dental plan that sets fees for dental services that are not covered services.
3. For the purposes of [this section](#):
 - a. “Covered services” means services reimbursed under the dental plan.
 - b. “Dental plan” means any policy or contract of insurance which provides for coverage of dental services not in connection with a medical plan that provides for the coverage of medical services.
4. Nothing in [this section](#) shall be construed as limiting the ability of an insurer or a third-party administrator to restrict any of the following as they relate to covered services:
 - a. Balance billing.
 - b. Waiting periods.
 - c. Frequency limitations.
 - d. Deductibles.
 - e. Maximum annual benefits.

2010 Acts, ch 1179, §1

514C.4 Mandated coverage for mammography.

1. a. A policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide minimum mammography examination coverage, including, but not limited to, the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state.
 - (1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
 - (2) An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).
 - (3) An individual or group health maintenance organization contract regulated under [chapter 514B](#).
 - (4) An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.
- b. A long-term care policy or contract is specifically excluded from regulation under [this section](#).
2. As used in [this section](#), “*minimum mammography examination coverage*” means benefits which are better than or equal to the following minimum requirements:
 - a. One baseline mammogram for any woman who is thirty-five through thirty-nine years of age, or more frequent mammograms if recommended by the woman’s physician.

b. A mammogram every two years for any woman who is forty through forty-nine years of age, or more frequently if recommended by the woman's physician.

c. A mammogram every year for any woman who is fifty years of age or older, or more frequently if recommended by the woman's physician.

3. Mammogram benefits may be subject to any policy or contract provisions which apply generally to other services covered by the policy or contract.

4. The commissioner of insurance shall adopt rules under [chapter 17A](#) necessary to implement [this section](#).

[89 Acts, ch 289, §1](#); [92 Acts, ch 1162, §32, 33](#); [2003 Acts, ch 135, §1 – 3](#); [2012 Acts, ch 1023, §157](#)

514C.5 Prescription drug benefit restrictions.

1. A group policy or contract providing for third-party payment or prepayment for prescription drugs shall not require a person covered under the policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for prescription drugs if the pharmacy selected by the covered person agrees to provide pharmaceutical services under the same terms and conditions as those provided by the mail order pharmacy.

2. Group third-party payor policies or contracts delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1990, are subject to [this section](#), including but not limited to the following classes:

- a. A group accident and sickness insurance policy.
- b. A group hospital or medical service contract.
- c. A group health maintenance organization contract.
- d. A group Medicare supplemental policy.

[90 Acts, ch 1130, §1](#)

514C.6 Uniformity of treatment — employee welfare benefit plans.

1. A statutory provision to mandate a health care coverage or service, or to mandate the offering of a health care coverage or service, applies to all state-regulated third-party payors and to employee welfare benefit plans described in 29 U.S.C. §1001 et seq. However, if an employee welfare benefit plan subject to federal regulation is not subject to a substantially similar requirement, the statutory provision does not apply to a state-regulated third-party payor until the employee welfare benefit plans are subject to a substantially similar standard under federal regulations as determined by the commissioner.

2. For purposes of [this section](#) unless the context otherwise requires, a third-party payor means:

- a. An accident and sickness insurer, subject to [chapter 509](#) or [514A](#).
- b. A nonprofit health service corporation, subject to [chapter 514](#).
- c. A health maintenance organization, subject to [chapter 514B](#).

d. Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

[91 Acts, ch 213, §20](#)

Referred to in [§514C.7](#), [§514C.11](#), [§514C.12](#), [§514C.18](#), [§514C.19](#), [§514C.20](#), [§514C.22](#), [§514C.23](#), [§514C.24](#), [§514C.25](#), [§514C.26](#), [§514C.27](#), [§514C.28](#), [§514C.29](#), [§514C.30](#)

514C.7 Prohibition on restricting coverage in certain instances involving a diagnosis of a fibrocystic condition.

Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a third-party payor as defined in that section shall not deny or fail to renew, or include an exception to or exclusion of benefits in, a policy or contract of individual or group accident and sickness insurance solely based upon an insured being diagnosed as having a fibrocystic condition.

[92 Acts, ch 1046, §1](#)

514C.8 Coordination of health care benefits with state medical assistance.

1. An insurer, health maintenance organization, or hospital and medical service plan providing health care coverage to individuals in this state shall not consider the availability

of or eligibility for medical assistance under Tit. XIX of the federal Social Security Act and [chapter 249A](#), when determining eligibility of the individual for coverage or calculating payments to the individual under the health care coverage plan.

2. The state acquires the rights of an individual to payment from an insurer, health maintenance organization, or hospital or medical service plan to the extent payment for covered expenses is made pursuant to [chapter 249A](#) for health care items or services provided to the individual. Upon presentation of proof that payment was made pursuant to [chapter 249A](#) for covered expenses, the insurer, health maintenance organization, or hospital or medical service plan shall make payment to the state medical assistance program to the extent of the coverage provided in the policy or contract.

3. An insurer shall not impose requirements on the state with respect to the assignment of rights pursuant to [this section](#) that are different from the requirements applicable to an agent or assignee of a covered individual.

4. For purposes of [this section](#), “insurer” means an entity which offers a health benefit plan, including a group health plan under the federal Employee Retirement Income Security Act of 1974.

[95 Acts, ch 185, §13; 2010 Acts, ch 1061, §180](#)

514C.9 Medical support — insurance requirements.

1. An insurer shall not deny coverage or enrollment of a child under the health plan of the obligor upon any of the following grounds:

a. The child is born out of wedlock.

b. The child is not claimed as a dependent on the obligor’s federal income tax return.

c. The child does not reside with the obligor or in the insurer’s service area. [This section](#) shall not be construed to require a health maintenance organization regulated under [chapter 514B](#) to provide any services or benefits for treatment outside of the geographic area described in its certificate of authority which would not be provided to a member outside of that geographic area pursuant to the terms of the health maintenance organization’s contract.

2. An insurer of an obligor providing health care coverage to the child for which the obligor is legally responsible to provide support shall do all of the following:

a. Provide information to the obligee or other legal custodian of the child as necessary for the child to obtain benefits through the coverage of the insurer.

b. Allow the obligee or other legal custodian of the child, or the provider with the approval of the obligee or other legal custodian of the child, to submit claims for covered services without the approval of the obligor.

c. Make payment on a claim submitted in paragraph “b” directly to the obligee or other legal custodian of the child, the provider, or the state medical assistance agency for claims submitted by the obligee or other legal custodian of the child, by the provider with the approval of the obligee or other legal custodian of the child, or by the state medical assistance agency.

3. If an obligor is required by a court order or administrative order to provide health coverage for a child and the obligor is eligible for dependent health coverage, the insurer shall do all of the following:

a. Allow the obligor to enroll under dependent coverage a child who is eligible for coverage pursuant to the applicable terms and conditions of the health benefit plan and the standard enrollment guidelines of the insurer without regard to an enrollment season restriction.

b. Enroll a child who is eligible for coverage under the applicable terms and conditions of the health benefit plan and the standard enrollment guidelines of the insurer, without regard to any time of enrollment restriction, under dependent coverage upon application by the obligee or other legal custodian of the child or by the department of human services in the event an obligor required by a court order or administrative order fails to apply for coverage for the child.

c. Maintain coverage and not cancel the child’s enrollment unless the insurer obtains satisfactory written evidence of any of the following:

(1) The court order or administrative order is no longer in effect.

(2) The child is eligible for or will enroll in comparable health coverage through an insurer which shall take effect not later than the effective date of the cancellation of enrollment of the original coverage.

(3) The employer has eliminated dependent health coverage for its employees.

(4) The obligor is no longer paying the required premium because the employer no longer owes the obligor compensation, or because the obligor's employment has terminated and the obligor has not elected to continue coverage.

4. A group health plan shall establish reasonable procedures to determine whether a child is covered under a qualified medical child support order issued pursuant to [chapter 252E](#). The procedures shall be in writing, provide for prompt notice of each person specified in the medical child support order as eligible to receive benefits under the group health plan upon receipt by the plan of the medical child support order, and allow an obligee or other legal custodian of the child under [chapter 252E](#) to designate a representative for receipt of copies of notices in regard to the medical child support order that are sent to the obligee or other legal custodian of the child and the department of human services' child support recovery unit.

5. For purposes of [this section](#), unless the context otherwise requires:

a. "Child" means a person, other than an obligee's spouse or former spouse, who is recognized under a qualified medical child support order as having a right to enrollment under a group health plan as the obligor's dependent.

b. "Court order" or "administrative order" means a ruling by a court or administrative agency in regard to the support an obligor shall provide to the obligor's child.

c. "Insurer" means an entity which offers a health benefit plan.

d. "Obligee" means an obligee as defined in [section 252E.1](#).

e. "Obligor" means an obligor as defined in [section 252E.1](#).

f. "Qualified medical child support order" means a child support order which creates or recognizes a child's right to receive health benefits for which the child is eligible under a group health benefit plan, describes or determines the type of coverage to be provided, specifies the length of time for which the order applies, and specifies the plan to which the order applies.

[95 Acts, ch 185, §14](#)

514C.10 Coverage for adopted child.

1. *Definitions.* For purposes of [this section](#), unless the context otherwise requires:

a. "Child" means, with respect to an adoption or a placement for adoption of a child, an individual who has not attained age eighteen as of the date of the issuance of a final adoption decree, or upon an interlocutory adoption decree becoming a final adoption decree, as provided in [chapter 600](#), or as of the date of the placement for adoption.

b. "Placement for adoption" means the assumption and retention of a legal obligation for the total or partial support of the child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligation.

2. *Coverage required.* A policy or contract providing for third-party payment or repayment of health or medical expenses shall provide coverage benefits to a dependent child adopted by, or placed for adoption with, an insured or enrollee under the same terms and conditions as apply to a biological, dependent child of the insured or enrollee. The issuer of the policy or contract shall not restrict coverage under the policy or contract for a dependent child adopted by, or placed for adoption with, the insured or enrollee solely on the basis of a preexisting condition of such dependent child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement occurs while the insured or enrollee is eligible for coverage under the policy or contract. [This section](#) applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1995:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. An organized delivery system licensed by the director of public health.
[95 Acts, ch 185, §15](#)

514C.11 Services provided by licensed physician assistants and licensed advanced registered nurse practitioners.

Notwithstanding [section 514C.6](#), a policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a physician assistant licensed pursuant to [chapter 148C](#), or provided by an advanced registered nurse practitioner licensed pursuant to [chapter 152](#) and performed within the scope of the license of the licensed physician assistant or the licensed advanced registered nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under [chapter 148](#). The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a licensed physician assistant or licensed advanced registered nurse practitioner if the coverage is rejected for all providers of similar services. A policy or contract subject to [this section](#) shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than the restriction already imposed by law. [This section](#) applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1996, and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is later. [This section](#) does not apply to policyholders or subscribers eligible for coverage under Tit. XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan. For the purposes of [this section](#), third-party payment or prepayment includes an individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#), an individual or group health maintenance organization contract issued and regulated under [chapter 514B](#), an organized delivery system contract regulated under rules adopted by the director of public health, or a preferred provider organization contract regulated pursuant to [chapter 514F](#). Nothing in [this section](#) shall be interpreted to require an individual or group health maintenance organization, an organized delivery system, or a preferred provider organization or arrangement to provide payment or prepayment for services provided by a licensed physician assistant or licensed advanced registered nurse practitioner unless the physician assistant's supervising physician, the physician-physician assistant team, the advanced registered nurse practitioner, or the advanced registered nurse practitioner's collaborating physician has entered into a contract or other agreement to provide services with the individual or group health maintenance organization, the organized delivery system, or the preferred provider organization or arrangement.

[96 Acts, ch 1169, §1; 2008 Acts, ch 1088, §130](#)

514C.12 Postdelivery benefits and care.

1. Notwithstanding [section 514C.6](#), a person who provides an individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to [chapter 509](#), [509A](#), [514](#), or [514A](#) or an individual or group health maintenance organization contract issued and regulated under [chapter 514B](#), which is delivered, amended, or renewed on or after July 1, 1996, and which provides maternity benefits, which are not limited to complications of pregnancy, or newborn care benefits, shall not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician after consultation with the mother and in accordance with guidelines adopted by rule by the commissioner. The guidelines adopted by rule shall be consistent with or may adopt by reference the guidelines for perinatal care established by the American

academy of pediatrics and the American college of obstetricians and gynecologists which provide that when complications are not present, the postpartum hospital stay ranges from a minimum of forty-eight hours for a vaginal delivery to a minimum of ninety-six hours for a cesarean birth, excluding the day of delivery. The guidelines adopted by rule by the commissioner shall also provide that in the event of a discharge from the hospital prior to the minimum stay established in the guidelines, a postdischarge follow-up visit shall be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician, in accordance with the guidelines.

2. When performing utilization review of inpatient hospital services related to maternity and newborn care, including but not limited to length of postdelivery stay and postdischarge follow-up care, any person who provides an individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to [chapter 509](#), [509A](#), [514](#), or [514A](#), or an individual or group health maintenance organization contract issued and regulated under [chapter 514B](#), shall use the guidelines adopted by rule by the commissioner, and shall not deselect, require additional documentation, require additional utilization review, terminate services to, reduce payment to, or in any manner provide a disincentive to an attending physician solely on the basis that the attending physician provided or directed the provision of services in compliance with the guidelines adopted by rule.

3. Preauthorization or precertification for a hospital stay or for a postdischarge follow-up visit in accordance with the guidelines adopted by rule by the commissioner shall not be required.

[96 Acts, ch 1202, §1](#)

514C.13 Group managed care health plans — requirements attached to limited provider network plan offers.

1. As used in [this section](#), unless the context otherwise requires:

a. “*Carrier*” means an entity that provides health benefit plans in this state. “*Carrier*” includes an insurance company, group hospital or medical service corporation, health maintenance organization, multiple employer welfare arrangement, and any other person providing health benefit plans in this state subject to regulation by the commissioner of insurance.

b. “*Health benefit plan*” means a policy, certificate, or contract providing hospital or medical coverage, benefits, or services rendered by a health care provider. “*Health benefit plan*” does not include a group conversion plan, accident-only, specific-disease, short-term hospital or medical hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance.

c. “*Health care provider*” means a hospital licensed pursuant to [chapter 135B](#), a person licensed under [chapter 148](#), [148C](#), [149](#), [151](#), or [154](#), or a person licensed as an advanced registered nurse practitioner under [chapter 152](#).

d. “*Indemnity plan*” means a hospital or medical expense-incurred policy, certificate, or contract, major medical expense insurance, or hospital or medical service plan contract.

e. “*Large employer*” means a person actively engaged in business who, during at least fifty percent of the employer’s working days during the preceding calendar year, employed more than fifty full-time equivalent employees.

f. “*Limited provider network plan*” means a managed care health plan which limits access to or coverage for services to selected health care providers who are under contract with the managed care health plan.

g. “*Managed care health plan*” means a health benefit plan that selects and contracts with health care providers; manages and coordinates health care delivery; monitors necessity, appropriateness, and quality of health care delivered by health care providers; and performs utilization review and cost control.

h. “Organized delivery system” means an organized delivery system as defined in [section 513C.3](#).

i. “Point of service plan option” means a provision in a managed care health plan that permits insureds, enrollees, or subscribers access to health care from health care providers who have not contracted with the managed care health plan.

j. “Small employer” means a person actively engaged in business who, during at least fifty percent of the employer’s working days during the preceding calendar year, employed at least one and not more than fifty full-time equivalent employees.

2. A carrier or organized delivery system which offers to a small employer a limited provider network plan to provide health care services or benefits to the small employer’s employees shall also offer to the small employer a point of service option to the limited provider network plan.

3. A carrier or organized delivery system which offers to a large employer a limited provider network plan to provide health care services or benefits to the large employer’s employees shall also offer to the large employer one or more of the following:

a. A point of service plan option to the limited provider network plan. The price of the point of service plan option shall be actuarially determined.

b. A managed care health plan that is not a limited provider network plan.

c. An indemnity plan.

4. A large employer that offers a limited provider network plan to its employees shall also offer to its employees one or more of the following:

a. A point of service plan option to the limited provider network plan.

b. A managed care health plan that is not a limited provider network plan.

c. An indemnity plan.

[97 Acts, ch 88, §1; 2008 Acts, ch 1088, §131; 2011 Acts, ch 70, §27, 49](#)

Referred to in [§505.25, §514I.6](#)

514C.14 Continuity of care — pregnancy.

1. Except as provided under [subsection 2 or 3](#), a carrier, as defined in [section 513B.2](#), an organized delivery system authorized under 1993 Iowa Acts, ch. 158, or a plan established pursuant to [chapter 509A](#) for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person’s physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under [chapter 509A](#), which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

[99 Acts, ch 41, §1](#)

514C.15 Treatment options.

A carrier, as defined in [section 513B.2](#); an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the director of public health; or a plan established pursuant to [chapter 509A](#) for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier’s, organized delivery system’s, or plan’s position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process

established by the carrier, organized delivery system, or [chapter 509A](#) plan, or established by a person contracting with the carrier, organized delivery system, or [chapter 509A](#) plan.

[99 Acts, ch 41, §2](#)

514C.16 Emergency room services.

1. A carrier, as defined in [section 513B.2](#); an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the director of public health; or a plan established pursuant to [chapter 509A](#) for public employees, which provides coverage for emergency services, is responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize an emergency medical condition shall be considered covered emergency services.

3. For purposes of [this section](#), unless the context otherwise requires:

a. “*Emergency medical condition*” means a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. “*Emergency services*” means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

[99 Acts, ch 41, §3](#)

514C.17 Continuity of care — terminal illness.

1. Except as provided under [subsection 2 or 3](#), if a carrier, as defined in [section 513B.2](#), an organized delivery system authorized under 1993 Iowa Acts, ch. 158, or a plan established pursuant to [chapter 509A](#) for public employees, terminates its contract with a participating health care provider; a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual’s treating physician licensed under [chapter 148](#) may continue to receive coverage for treatment received from the covered individual’s physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person’s treating physician licensed under [chapter 148](#) who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. Notwithstanding [subsections 1 and 2](#), a carrier, organized delivery system, or plan established under [chapter 509A](#) which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

[99 Acts, ch 41, §4; 2008 Acts, ch 1088, §132](#)

514C.18 Diabetes coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for the cost associated with equipment, supplies, and

self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a physician licensed under [chapter 148](#). Coverage benefits shall include coverage for the cost associated with all of the following:

a. Equipment and supplies.

b. Payment for diabetes self-management training and education only under all of the following conditions:

(1) The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.

(2) The diabetes self-management training and education program is certified by the Iowa department of public health. The department shall consult with the American diabetes association, Iowa affiliate, in developing the standards for certification of diabetes education programs that cover at least ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period and up to two hours of follow-up training for each subsequent year for each individual diagnosed by a physician with any type of diabetes mellitus.

2. a. [This section](#) applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

(3) An individual or group health maintenance organization contract regulated under [chapter 514B](#).

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to [chapter 509A](#) for public employees.

(6) An organized delivery system licensed by the director of public health.

b. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

[99 Acts, ch 75, §1; 99 Acts, ch 208, §58; 2008 Acts, ch 1088, §133; 2009 Acts, ch 139, §1, 2; 2011 Acts, ch 70, §28](#)

2009 amendment takes effect May 22, 2009, and applies to the classes of third-party payment provider contracts or policies that are delivered, issued for delivery, continued, or renewed on or after July 1, 2009; [2009 Acts, ch 139, §2](#)

514C.19 Prescription contraceptive coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group policy or contract providing for third-party payment or prepayment of health or medical expenses shall not do either of the following:

a. Exclude or restrict benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and which are approved by the United States food and drug administration, or generic equivalents approved as substitutable by the United States food and drug administration, if such policy or contract provides benefits for other outpatient prescription drugs or devices.

b. Exclude or restrict benefits for outpatient contraceptive services which are provided for the purpose of preventing conception if such policy or contract provides benefits for other outpatient services provided by a health care professional.

2. A person who provides a group policy or contract providing for third-party payment or prepayment of health or medical expenses which is subject to [subsection 1](#) shall not do any of the following:

a. Deny to an individual eligibility, or continued eligibility, to enroll in or to renew coverage under the terms of the policy or contract because of the individual's use or potential use of such prescription contraceptive drugs or devices, or use or potential use of outpatient contraceptive services.

b. Provide a monetary payment or rebate to a covered individual to encourage such individual to accept less than the minimum benefits provided for under [subsection 1](#).

c. Penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribes contraceptive drugs or devices, or provides contraceptive services.

d. Provide incentives, monetary or otherwise, to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services.

3. [This section](#) shall not be construed to prevent a third-party payor from including deductibles, coinsurance, or copayments under the policy or contract, as follows:

a. A deductible, coinsurance, or copayment for benefits for prescription contraceptive drugs shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription drug for which coverage under the policy or contract is provided.

b. A deductible, coinsurance, or copayment for benefits for prescription contraceptive devices shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription device for which coverage under the policy or contract is provided.

c. A deductible, coinsurance, or copayment for benefits for outpatient contraceptive services shall not be greater than such deductible, coinsurance, or copayment for any outpatient health care services for which coverage under the policy or contract is provided.

4. [This section](#) shall not be construed to require a third-party payor under a policy or contract to provide benefits for experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, except to the extent that such policy or contract provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

5. [This section](#) shall not be construed to limit or otherwise discourage the use of generic equivalent drugs approved by the United States food and drug administration, whenever available and appropriate. [This section](#), when a brand name drug is requested by a covered individual and a suitable generic equivalent is available and appropriate, shall not be construed to prohibit a third-party payor from requiring the covered individual to pay a deductible, coinsurance, or copayment consistent with [subsection 3](#), in addition to the difference of the cost of the brand name drug less the maximum covered amount for a generic equivalent.

6. A person who provides an individual policy or contract providing for third-party payment or prepayment of health or medical expenses shall make available a coverage provision that satisfies the requirements in [subsections 1 through 5](#) in the same manner as such requirements are applicable to a group policy or contract under those subsections. The policy or contract shall provide that the individual policyholder may reject the coverage provision at the option of the policyholder.

7. a. [This section](#) applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2000:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

(3) An individual or group health maintenance organization contract regulated under [chapter 514B](#).

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to [chapter 509A](#) for public employees.

(6) An organized delivery system licensed by the director of public health.

b. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

[2000 Acts, ch 1120, § 1](#)

514C.20 Mandated coverage for dental care — anesthesia and certain hospital charges.

1. Notwithstanding [section 514C.6](#), and subject to the terms and conditions of the policy or contract, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for the administration of general anesthesia and hospital or ambulatory surgical center charges related to the provision of dental care services provided to any of the following covered individuals:

a. A child under five years of age upon a determination by a licensed dentist and the child's treating physician licensed pursuant to [chapter 148](#), that such child requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective.

b. Any individual upon a determination by a licensed dentist and the individual's treating physician licensed pursuant to [chapter 148](#), that such individual has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

2. Prior authorization of hospitalization or ambulatory surgical center for dental care procedures may be required in the same manner that prior authorization is required for hospitalization for other coverages under the contract or policy.

3. [This section](#) applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2000:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

e. A plan established pursuant to [chapter 509A](#) for public employees.

f. An organized delivery system licensed by the director of public health.

4. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

[2000 Acts, ch 1193, § 1; 2008 Acts, ch 1088, § 134](#)

514C.21 Coverage for immunizations — mercury.

1. Third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2006, that provide reimbursement for immunizations shall provide reimbursement for immunizations containing no more than trace amounts of mercury at the acquisition cost rate for immunizations containing no more than trace amounts of mercury. For the purposes of [this section](#), "trace amounts" means trace amounts as defined by the United States food and drug administration.

2. For the purposes of [this section](#), “*third-party payment provider contracts or policies*” includes:

- a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
- b. An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).
- c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).
- d. An organized delivery system licensed by the director of public health.

[2004 Acts, ch 1159, §2](#)

Organized delivery systems authorized; see [93 Acts, ch 158, §3](#)

514C.22 Biologically based mental illness coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group policy, contract, or plan providing for third-party payment or prepayment of health, medical, and surgical coverage benefits issued by a carrier, as defined in [section 513B.2](#), or by an organized delivery system authorized under 1993 Iowa Acts, ch. 158, shall provide coverage benefits for treatment of a biologically based mental illness if either of the following is satisfied:

a. The policy, contract, or plan is issued to an employer who on at least fifty percent of the employer’s working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. The policy, contract, or plan is issued to a small employer as defined in [section 513B.2](#), and such policy, contract, or plan provides coverage benefits for the treatment of mental illness.

2. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a plan established pursuant to [chapter 509A](#) for public employees shall provide coverage benefits for treatment of a biologically based mental illness.

3. For purposes of [this section](#), “*biologically based mental illness*” means the following psychiatric illnesses:

- a. Schizophrenia.
- b. Bipolar disorders.
- c. Major depressive disorders.
- d. Schizo-affective disorders.
- e. Obsessive-compulsive disorders.
- f. Pervasive developmental disorders.
- g. Autistic disorders.

4. The commissioner, by rule, shall define the biologically based mental illnesses identified in [subsection 3](#). Definitions established by the commissioner shall be consistent with definitions provided in the most recent edition of the American psychiatric association’s diagnostic and statistical manual of mental disorders, as such definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

5. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

6. A carrier, organized delivery system, or plan established pursuant to [chapter 509A](#) may manage the benefits provided through common methods including, but not limited to, providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system

for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

7. a. A group policy, contract, or plan covered under [this section](#) shall not impose an aggregate annual or lifetime limit on biologically based mental illness coverage benefits unless the policy, contract, or plan imposes an aggregate annual or lifetime limit on substantially all health, medical, and surgical coverage benefits.

b. A group policy, contract, or plan covered under [this section](#) that imposes an aggregate annual or lifetime limit on substantially all health, medical, and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on biologically based mental illness coverage benefits that is less than the aggregate annual or lifetime limit imposed on substantially all health, medical, and surgical coverage benefits.

8. A group policy, contract, or plan covered under [this section](#) shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy, contract, or plan may also include deductibles, coinsurance, or copayments, provided the amounts and extent of such deductibles, coinsurance, or copayments applicable to other health, medical, or surgical services coverage under the policy, contract, or plan are the same. It is not a violation of [this section](#) if the policy, contract, or plan excludes entirely from coverage benefits for the cost of providing the following:

- a. Marital, family, educational, developmental, or training services.
- b. Care that is substantially custodial in nature.
- c. Services and supplies that are not medically necessary or clinically appropriate.
- d. Experimental treatments.

9. [This section](#) applies to third-party payment provider policies or contracts and to plans established pursuant to [chapter 509A](#) that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2006.

[2005 Acts, ch 91, §1](#)

Referred to in [§135H.3, §514C.28](#)

514C.23 Human papilloma virus vaccinations — coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a contract, policy, or plan providing for third-party payment or prepayment of health or medical expenses that provides coverage benefits for any vaccination or immunization shall provide coverage benefits for a vaccination for human papilloma virus, including but not limited to the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2009:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. A plan established pursuant to [chapter 509A](#) for public employees.

2. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

3. As used in [this section](#), "human papilloma virus" means the human papilloma virus as defined by the centers for disease control and prevention of the United States department of health and human services.

4. The commissioner of insurance shall adopt rules pursuant to [chapter 17A](#) as necessary to administer [this section](#).

[2008 Acts, ch 1108, §1](#)

514C.24 Cancer treatment — coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a contract, policy, or plan providing for third-party payment or prepayment for cancer treatment shall not discriminate between coverage benefits for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and intravenously administered or injected cancer medications that are covered, regardless of formulation or benefit category determination by the contract, policy, or plan.

2. The provisions of [this section](#) shall apply to all of the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2009:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. A plan established pursuant to [chapter 509A](#) for public employees.

3. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, long-term care, basic hospital, and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

4. The commissioner of insurance shall adopt rules pursuant to [chapter 17A](#) as necessary to administer [this section](#).

[2009 Acts, ch 179, §183](#)

514C.25 Coverage for prosthetic devices.

1. a. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for medically necessary prosthetic devices when prescribed by a physician licensed under [chapter 148](#). Such coverage benefits for medically necessary prosthetic devices shall provide coverage for medically necessary prosthetic devices that, at a minimum, equals the coverage and payment for medically necessary prosthetic devices provided under the most recent federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. §1395k, 1395l, and 1395m, and [42 C.F.R. §410.100](#), [414.202](#), [414.210](#), and [414.228](#), as applicable.

b. For the purposes of [this section](#), “*prosthetic device*” means an artificial limb device to replace, in whole or in part, an arm or leg.

2. a. [This section](#) applies to the following classes of third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2009:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).

(3) An individual or group health maintenance organization contract regulated under [chapter 514B](#).

(4) A plan established pursuant to [chapter 509A](#) for public employees.

(5) An organized delivery system licensed by the director of public health.

b. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to

liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

3. Notwithstanding [subsection 1](#), paragraph “a”, a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses that is issued for use in connection with a health savings account as authorized under Tit. XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, may impose the same deductibles and out-of-pocket limits on the prosthetics coverage benefits required in [this section](#) that apply to substantially all health, medical, and surgical coverage benefits under the policy, contract, or plan.

[2009 Acts, ch 89, §1](#)

514C.26 Approved cancer clinical trials coverage.

1. *Definitions.* For purposes of [this section](#), unless the context otherwise requires:

a. “*Approved cancer clinical trial*” means a scientific study of a new therapy for the treatment of cancer in human beings that meets the requirements set forth in [subsection 3](#) and consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions.

b. “*Institutional review board*” means a board, committee, or other group formally designated by an institution and approved by the national institutes of health, office for protection from research risks, to review, approve the initiation of, and conduct periodic review of biomedical research involving human subjects. “*Institutional review board*” means the same as “institutional review committee” as used in section 520(g) of the federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. §301 et seq.

c. (1) “*Routine patient care costs*” means medically necessary services or treatments that are a benefit under a contract or policy providing for third-party payment or prepayment of health or medical expenses that would be covered if the patient were receiving standard cancer treatment.

(2) “*Routine patient care costs*” does not include any of the following:

(a) Costs of any treatments, procedures, drugs, devices, services, or items that are the subject of the approved cancer clinical trial or any other investigational treatments, procedures, drugs, devices, services, or items.

(b) Costs of nonhealth care services that the patient is required to receive as a result of participation in the approved cancer clinical trial.

(c) Costs associated with managing the research that is associated with the approved cancer clinical trial.

(d) Costs that would not be covered by the third-party payment provider if noninvestigational treatments were provided.

(e) Costs of any services, procedures, or tests provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient participating in an approved cancer clinical trial.

(f) Costs paid for, or not charged for, by the approved cancer clinical trial providers.

(g) Costs for transportation, lodging, food, or other expenses for the patient, a family member, or a companion of the patient that are associated with travel to or from a facility where an approved cancer clinical trial is conducted.

(h) Costs for services, items, or drugs that are eligible for reimbursement from a source other than a patient's contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial.

(i) Costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology.

(j) Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for participation in the cancer clinical trial. Nothing in this subparagraph division shall limit payment for treatments, services, procedures, tests, or drugs that are otherwise a covered benefit under subparagraph (1).

d. *“Therapeutic intent”* means that a treatment is aimed at improving a patient’s health outcome relative to either survival or quality of life.

2. *Coverage required.* Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for routine patient care costs incurred for cancer treatment in an approved cancer clinical trial to the same extent that such policy or contract provides coverage for treating any other sickness, injury, disease, or condition covered under the policy or contract, if the insured has been referred for such cancer treatment by two physicians who specialize in oncology and the cancer treatment is given pursuant to an approved cancer clinical trial that meets the criteria set forth in [subsection 3](#). Services that are furnished without charge to a participant in the approved cancer clinical trial are not required to be covered as routine patient care costs pursuant to [this section](#).

3. *Criteria.* Routine patient care costs for cancer treatment given pursuant to an approved cancer clinical trial shall be covered pursuant to [this section](#) if all of the following requirements are met:

a. The treatment is provided with therapeutic intent and is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following:

- (1) The national institutes of health.
- (2) The United States food and drug administration.
- (3) The United States department of defense.
- (4) The United States department of veterans affairs.

b. The proposed treatment has been reviewed and approved by the applicable qualified institutional review board.

c. The available clinical or preclinical data indicate that the treatment that will be provided pursuant to the approved cancer clinical trial will be at least as effective as the standard therapy and is anticipated to constitute an improvement in therapeutic effectiveness for the treatment of the disease in question.

4. *Notice.* As soon as practical after the insured provides written consent to participate in an approved cancer clinical trial, the physician shall provide notice to the third-party payment provider of the insured’s intent to participate in an approved cancer clinical trial. Failure to provide such notice to the third-party payment provider shall not be the basis for denying the coverage required under [subsection 2](#).

5. *Applicability.*

a. [This section](#) applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2010:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to [chapter 509, 514, or 514A](#).

(3) An individual or group health maintenance organization contract regulated under [chapter 514B](#).

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to [chapter 509A](#) for public employees.

(6) An organized delivery system licensed by the director of public health.

b. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance.

[2010 Acts, ch 1013, §1; 2010 Acts, ch 1193, §61](#)

514C.27 Mental illness and substance abuse treatment coverage for veterans.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group policy or contract providing for third-party payment or prepayment of health or medical expenses issued by a carrier, as defined in [section 513B.2](#), or by an organized delivery system authorized under 1993 Iowa Acts, ch. 158, shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse if either of the following is satisfied:

a. The policy or contract is issued to an employer who on at least fifty percent of the employer's working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. The policy or contract is issued to a small employer as defined in [section 513B.2](#), and such policy or contract provides coverage benefits for the treatment of mental illness and substance abuse.

2. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a plan established pursuant to [chapter 509A](#) for public employees shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse as defined in [subsection 3](#).

3. For purposes of this section:

a. "*Mental illness*" means mental disorders as defined by the commissioner by rule.

b. "*Substance abuse*" means a pattern of pathological use of alcohol or a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn.

c. "*Veteran*" means the same as defined in [section 35.1](#).

4. The commissioner, by rule, shall define "*mental illness*" consistent with definitions provided in the most recent edition of the American psychiatric association's diagnostic and statistical manual of mental disorders, as the definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

5. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

6. A carrier, organized delivery system, or plan established pursuant to [chapter 509A](#) may manage the benefits provided through common methods including but not limited to providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

7. a. A group policy or contract or plan covered under this section shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits unless the policy or contract or plan imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits.

b. A group policy or contract or plan covered under this section that imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits which is less than the aggregate annual or lifetime limit imposed on substantially all medical and surgical coverage benefits.

8. A group policy or contract or plan covered under this section shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy or contract or plan may also include deductibles, coinsurance, or copayments, provided the amounts

and extent of such deductibles, coinsurance, or copayments applicable to other medical or surgical services coverage under the policy or contract or plan are the same. It is not a violation of this section if the policy or contract or plan excludes entirely from coverage benefits for the cost of providing the following:

- a. Care that is substantially custodial in nature.
- b. Services and supplies that are not medically necessary or clinically appropriate.
- c. Experimental treatments.

9. This section applies to third-party payment provider policies or contracts and plans established pursuant to [chapter 509A](#) delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011.

[2010 Acts, ch 1121, §15; 2014 Acts, ch 1026, §143; 2016 Acts, ch 1011, §95](#)

Subsection 5 amended

514C.28 Autism spectrum disorders coverage.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group plan established pursuant to [chapter 509A](#) for employees of the state providing for third-party payment or prepayment of health, medical, and surgical coverage benefits shall provide coverage benefits to covered individuals under twenty-one years of age for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders.

2. As used in [this section](#), unless the context otherwise requires:

a. “*Applied behavioral analysis*” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

b. “*Autism service provider*” means a person, or group providing treatment of autism spectrum disorders. An autism service provider that provides treatment of autism spectrum disorders that includes applied behavioral analysis shall be certified as a behavior analyst by the behavior analyst certification board or shall be a health professional licensed under [chapter 147](#).

c. “*Autism spectrum disorders*” means any of the pervasive developmental disorders including autistic disorder, Asperger’s disorder, and pervasive developmental disorders not otherwise specified. The commissioner, by rule, shall define “*autism spectrum disorders*” consistent with definitions provided in the most recent edition of the American psychiatric association’s diagnostic and statistical manual of mental disorders, as such definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

d. “*Diagnostic assessment of autism spectrum disorders*” means medically necessary assessment, evaluations, or tests performed by a licensed physician, licensed physician assistant, licensed psychologist, or licensed registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

e. “*Pharmacy care*” means medications prescribed by a licensed physician, licensed physician assistant, or licensed registered nurse practitioner and any assessment, evaluation, or test prescribed or ordered by a licensed physician, licensed physician assistant, or licensed registered nurse practitioner to determine the need for or effectiveness of such medications.

f. “*Psychiatric care*” means direct or consultative services provided by a licensed physician who specializes in psychiatry.

g. “*Psychological care*” means direct or consultative services provided by a licensed psychologist.

h. “*Rehabilitative care*” means professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvement in human behavior or to prevent loss of attained skill or function.

i. “*Therapeutic care*” means services provided by a licensed speech pathologist, licensed occupational therapist, or licensed physical therapist.

j. “*Treatment of autism spectrum disorders*” means treatment that is identified in

a treatment plan and includes medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care, and therapeutic care that is one of the following:

(1) Prescribed, ordered, or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed social worker, or licensed registered nurse practitioner.

(2) Provided by an autism service provider.

(3) Provided by a person, entity, or group that works under the direction of an autism service provider.

k. “*Treatment plan*” means a plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in consultation with the patient and the patient’s representative.

3. Coverage is required pursuant to [this section](#) in a maximum benefit amount of not more than thirty-six thousand dollars per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. Beginning in 2014, the commissioner shall, on or before April 1 of each calendar year, publish an adjustment to the maximum benefit required equal to the percentage change in the United States department of labor consumer price index for all urban consumers in the preceding year, and the published adjusted maximum benefit shall be applicable to group policies, contracts, or plans subject to [this section](#) that are issued or renewed on or after January 1 of the following calendar year. Payments made under a group plan subject to [this section](#) on behalf of a covered individual for treatment of a health condition unrelated to or distinguishable from the individual’s autism spectrum disorder shall not be applied toward any maximum benefit established under [this subsection](#).

4. Coverage required pursuant to [this section](#) shall be subject to copayment, deductible, and coinsurance provisions, and any other general exclusions or limitations of a group plan to the same extent as other medical or surgical services covered by the group plan.

5. Coverage required by [this section](#) shall be provided in coordination with coverage required for the treatment of autistic disorders pursuant to [section 514C.22](#).

6. [This section](#) shall not be construed to limit benefits which are otherwise available to an individual under a group plan.

7. [This section](#) shall not be construed to require coverage by a group plan of any service solely based on inclusion of the service in an individualized education program. Consistent with federal or state law and upon consent of the parent or guardian of a covered individual, the treatment of autism spectrum disorders may be coordinated with any services included in an individualized education program. However, coverage for the treatment of autism spectrum disorders shall not be contingent upon coordination of services with an individualized education program.

8. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

9. A plan established pursuant to [chapter 509A](#) for employees of the state may manage the benefits provided through common methods including but not limited to providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

10. An insurer may review a treatment plan for treatment of autism spectrum disorders once every six months, subject to its utilization review requirements, including case management, concurrent review, and other managed care provisions. A more or less frequent review may be agreed upon by the insured and the licensed physician or licensed psychologist developing the treatment plan.

11. For the purposes of [this section](#), the results of a diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than twelve months, unless a licensed physician or licensed psychologist determines that a more frequent assessment is necessary.

12. The commissioner shall adopt rules pursuant to [chapter 17A](#) to implement and administer [this section](#).

13. [This section](#) applies to plans established pursuant to [chapter 509A](#) for employees of the state that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011.

[2010 Acts, ch 1193, §131](#)

Referred to in [§225D.1](#), [§225D.2](#)

514C.29 Services provided by a doctor of chiropractic.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall not impose a copayment or coinsurance amount on an insured for services provided by a doctor of chiropractic licensed pursuant to [chapter 151](#) that is greater than the copayment or coinsurance amount imposed on the insured for services provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under [chapter 148](#) for the same or a similar diagnosed condition even if a different nomenclature is used to describe the condition for which the services are provided.

2. [This section](#) applies to the following classes of third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2012:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. A plan established pursuant to [chapter 509A](#) for public employees.

e. An organized delivery system licensed by the director of public health.

3. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

[2012 Acts, ch 1138, §36](#)

514C.30 Services provided by a physical therapist, occupational therapist, or speech pathologist.

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall not impose a copayment or coinsurance amount on an insured for services provided by a physical therapist licensed pursuant to [chapter 148A](#), by an occupational therapist licensed pursuant to [chapter 148B](#), or by a speech pathologist licensed pursuant to [chapter 154F](#) that is greater than the copayment or coinsurance amount imposed on the insured for services provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under [chapter 148](#) for the same or a similar diagnosed condition even if a different nomenclature is used to describe the condition for which the services are provided.

2. [This section](#) applies to the following classes of third-party payment provider policies, contracts, or plans delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2015:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to [chapter 509](#), [514](#), or [514A](#).

c. An individual or group health maintenance organization contract regulated under [chapter 514B](#).

d. A plan established pursuant to [chapter 509A](#) for public employees.

e. An organized delivery system licensed by the director of public health.

3. [This section](#) shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

[2015 Acts, ch 137, §101, 162, 163](#)