513C.7 Availability of coverage.

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

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

b. An organized delivery system shall file with the director, in a form and manner prescribed by the director, the basic or standard health benefit plan to be used by the organized delivery system. A basic or standard health benefit plan filed pursuant to this paragraph may be used by the organized delivery system beginning thirty days after it is filed unless the director disapproves of its use.

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

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

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

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

(3) A pregnancy existing on the effective date of coverage.

b. A carrier or an organized delivery system shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. For purposes of this section, periods of coverage under medical assistance provided pursuant to chapter 249A or 514I, or Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act shall not be counted with respect to the sixty-three-day requirement.

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

95 Acts, ch 5, §9; 97 Acts, ch 103, §3739; 99 Acts, ch 165, §9, 10; 2003 Acts, ch 91, §24; 2004 Acts, ch 1158, §2, 21