

191—35.23(509) Definitions.

"Affiliation period" means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

"Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit" under the plan.

"Bona fide association" means, with respect to group health insurance coverage offered in Iowa, an association that meets the following conditions:

1. Has been actively in existence for at least five years.
2. Has been formed and maintained in good faith for purposes other than obtaining insurance.
3. Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of any employee.
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member.
5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Commissioner" means the commissioner of insurance.

"Continuation coverage" means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar state program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

"Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
4. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.
5. 10 U.S.C. ch. 55.
6. A health or medical care program provided through the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C. ch. 89.
9. A public health plan as defined under federal regulations.
10. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).
11. A short-term limited-duration policy.

"Director" means the director of public health appointed pursuant to Iowa Code section 135.2.

"Division" means the division of insurance.

"Eligible employee" means an individual who is eligible to enroll in group health insurance coverage offered to a group health plan maintained by an employer, in accordance with the terms of the group health plan.

“*Employee*” means any individual employed by an employer.

“*Enrollment date*” means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

“*Exhaustion of continuation coverage*” means that an individual’s continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted continuation coverage if:

1. Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or
2. When the individual no longer resides, lives, or works in a service area of an HMO or similar program, whether or not within the choice of the individual, and there is no other continuation coverage available to the individual.

“*Group health plan*” means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1. For purposes of this rule, “medical care” means amounts paid for any of the following:
 - The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
 - Transportation primarily for and essential to medical care referred to in this definition.
 - Insurance covering medical care referred to in this definition.
2. For purposes of this division, a plan, fund, or program established or maintained by a partnership which, but for this paragraph, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.
3. With respect to a group health plan, the term “employer” includes a partnership with respect to a partner.
4. With respect to a group health plan the term “participant” includes the following:
 - With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.
 - With respect to a group health plan maintained by a self-employed individual, under which one or more of the self-employed individual’s employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual’s dependents may be eligible to receive benefits under the plan.

“*Health insurance coverage*” or “*health insurance plan*” means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

1. “Health insurance coverage” does not include any of the following:
 - Coverage for accident only, or disability income insurance.
 - Coverage issued as a supplement to liability insurance.
 - Liability insurance, including general liability insurance and automobile liability insurance.
 - Workers’ compensation or similar insurance.
 - Automobile medical payment insurance.
 - Credit-only insurance.
 - Coverage for on-site medical clinic care.
 - Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
 - Flexible spending accounts.

2. “Health insurance coverage” does not include benefits provided under a separate policy as follows:

- Limited scope dental or vision benefits.
- Benefits for long-term care, nursing home care, home health care, or community-based care.
- Short-term limited-duration insurance.
- Any other similar, limited benefits as provided by rule of the commissioner.
- Stop loss insurance coverage.

3. “Health insurance coverage” does not include benefits offered as independent noncoordinated benefits as follows:

- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance.

4. “Health insurance coverage” does not include Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided under insurance coverage.

5. “Group health insurance coverage” means health insurance coverage offered in connection with a group health plan.

“*Health maintenance organization*” or “*HMO*” means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514B.5.

“*Large employer*” means an employer employing two or more employees and which does not meet the definition of small employer under Iowa Code section 513B.2(16).

“*Late enrollee*” means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or health insurance coverage in connection with which it is issued, other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or health insurance coverage.

“*Network plan*” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

“*Plan year*” means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible/limit year used under the plan.
2. If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.
3. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer’s taxable year.

“*Preexisting condition exclusion*” means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual’s health status before the individual’s first day of coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

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

“Significant break in coverage” means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

“Special enrollment period” means a period other than the first period in which an eligible employee or a dependent is eligible to enroll under the terms of group health insurance coverage in connection with which it is issued, without regard to other enrollment periods defined under the health insurance coverage.

“Waiting period” means, with respect to group health insurance coverage and an eligible employee or a dependent who is potentially eligible for coverage under the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

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