191—71.14(513B) Basic health benefit plan and standard health plan policy forms.

71.14(1) The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in this rule. This rule provides the minimum benefit levels allowed and does not prevent carriers from voluntarily providing additional services to the basic health benefit plan or the standard health benefit plan.

71.14(2) The matrix and acceptable exclusions following this chapter are a guideline for the minimum benefit levels in a basic and standard health policy form.

71.14(3) Termination of pregnancy is to be covered in both policy forms when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard form.

71.14(4) A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license.

71.14(5) Prosthetic devices are covered when medically necessary.

71.14(6) Prescription oral contraceptives and contraceptive devices that are approved by the United States Food and Drug Administration are to be covered in both policy forms.

71.14(7) Both policy forms shall cover well baby care consistent with Iowa Administrative Code 191—Chapter 80.

71.14(8) The division has available "safe harbor" policy forms for the basic and standard health insurance plans required pursuant to Iowa Code chapter 513B. These are model forms approved by the division as meeting the minimum requirements of a basic and a standard policy.

SMALL EMPLOYER PRODUCTS

	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC	STANDARD
Calendar Year Deductibles (S/F)	$500 x 3	$500 x 2		
E.R. Copayment	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	60%	80%
Out-of-pocket per insured/family maximum	$4,800/$14,400	$2,000/$4,000	$4,000/$8,000 (excludes deductibles and copays)	$2,000/$4,000
Annual Maximum				
Lifetime Maximum	$250,000	$1,000,000	$250,000	$1,000,000
Pre-Existing	513B.10(3)	513B.10(3)	513B.10(3)	513B.10(3)
Late Entrant	513B.2(12)	513B.2(12)	513B.2(12)	513B.2(12)
Wellness	100% first $100 60% over $100	100% first $150 80% over $150	100% after $20 copay per visit	100% after $15 copay per visit
Maternity	60% Enrollee or Spouse Only	80% Enrollee or Spouse	60%	80%
PHYSICIAN SERVICES				
Office Visits	60%(1)	80%(2)	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	60%	80%
Inpatient	60%	80%	60%	80%
Outpatient	60%(1)	80%(2)	60%	80%
Vision Screening				
Vision Examinations				
Immunizations	60%(1)	80%(2)	60%	80%
Well Child	60%(1) (Deductible does not apply)	80%(2) (Deductible does not apply)	100% after $20 copay/visit	100% after $15 copay/visit
Pre-Natal/Post-Natal Outpatient Visits	60%(1)	80%(2)	100% after $50 copay/pregnancy	100% after $50 copay/pregnancy

	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC	STANDARD
Inpatient	60%	80%	60% of $400/admit	80% $200/admit
Prostheses	60%	80%	60%	80%
DME—including medical supplies	60%	80%	60%	80%
Ambulance-Emergency	60%	80%	60%	80%
Hospice	60%	80%	60%	80%
Home Health and Physician House Calls	60%	80%	60%	80%
ALCOHOLISM/ SUBSTANCE ABUSE				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)
MENTAL HEALTH				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)
RX	60%	80%	Copayment greater of $15 or 25%	Copayment greater of $10 or 25%
Transplants		80%		80%

(1)For wellness services, covered 100% first $100 and 60% over $100

(2)For wellness services, covered 100% first $150 and 80% over $150

(3)$50,000 lifetime max.

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

Except as specifically provided for, no benefits will be provided for services, supplies or charges:

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

12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;
13. Incurred after the date of termination of the insured's coverage;
14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;
16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;
17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
18. For custodial care, domiciliary care or rest cures;
19. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;
20. For screening examinations including X-ray examinations made without film;
21. For sterilization or reversal of sterilizations, or both;
22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;
23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;
28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;
29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;
30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;
31. For travel whether or not recommended by a physician;
32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;
33. For maternity care of dependent children except for complications of pregnancy which is covered as any other illness;
34. For services to the extent that those services are covered by Medicare;
35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);
36. For or related to the transplantation of animal or artificial organs or tissues;
37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;
38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;
39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;

40. For the purchase of wigs or cranial prosthesis;
41. For weekend admission charges, except for emergencies and nonscheduled maternity admissions;
42. For orthomolecular therapy including nutrients, vitamins and food supplements;
43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

71.14(9) All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.18.

[**ARC 6547C**, IAB 10/5/22, effective 11/9/22]