191—36.6(514D) Accident and sickness minimum standards for benefits. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subrules. No individual policy of accident and sickness insurance or nonprofit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the commissioner finds that such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in 36.7(12).

Nothing in this rule shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in this chapter.

Nonprofit hospital and medical service associations are subject to this chapter. When such associations are prohibited from issuing subscriber contracts which include all of the benefits required in 36.6(2) or 36.6(5), they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefit required. In such event, the combination of contracts will be considered to have been issued in compliance with this chapter.

36.6(1) *General rules.*

a. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

b. The terms "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 36.7(1)*"a."* The terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60 the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

c. In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancelable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse, to the age or for the durational period as specified in said definition.

d. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

e. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro-rata basis.

f. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

g. Policies providing skilled, or convalescent, or extended care benefits following hospitalization shall not condition the benefits upon admission to the nursing facility within a period of less than 14 days after discharge from the hospital.

h. Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of the date, the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

i. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

j. A policy may contain a provision relating to recurrent disabilities; provided, however, that no provision shall specify that a recurrent disability be separated by a period greater than six months.

k. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

l. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

m. Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

n. Termination of the policy shall be without prejudice to coverage for any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, or payment of the maximum benefits.

36.6(2) *"Basic hospital expense coverage"* is a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

a. Daily hospital room and board in an amount not less than the lesser of 80 percent of the charges for the semiprivate room accommodations or $100 per day;

b. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80 percent of the charges incurred up to at least $3,000 or ten times the daily hospital room and board benefits;

c. Hospital outpatient services consisting of (1) hospital services on the day surgery is performed, and (2) hospital services rendered within 72 hours after accidental injury, in an amount not less than $150, and (3) X-ray and laboratory tests, to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital in an amount not less than $100.

Benefits provided under *"a"* and *"b"* above may be provided subject to a combined deductible amount not in excess of $100.

36.6(3) *"Basic medical-surgical expense coverage"* is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

a. Surgical services:

(1) In amounts not less than those provided in a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least $1,000 for any one procedure; or

(2) Not less than 80 percent of the reasonable charges.

b. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or assistant) performing the surgical services:

(1) In an amount not less than 80 percent of the reasonable charges; or

(2) Fifteen percent of the surgical service benefit.

c. In-hospital medical services, consisting of physician services other than surgical care, rendered to a person who is a bed patient in a hospital for treatment of sickness or injury in an amount not less than 80 percent of the reasonable charges or $50 per day for not less than 21 days during one period of confinement.

36.6(4) *"Hospital confinement indemnity coverage"* is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $40 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

a. Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

b. Except as provided in 191—Chapter 38, division II, benefits shall be paid regardless of other coverage.

36.6(5) *Individual major medical expense coverage.*

a. "Individual major medical expense coverage" is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $500,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed $10,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 5 percent of the aggregate maximum limit under the policy for each covered person for at least:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) Not fewer than three of the following additional benefits:

1. In-hospital private duty registered nurse services.
2. Convalescent nursing care.
3. Diagnosis and treatment by a radiologist or physiotherapist.
4. Rental of special medical equipment, as defined by the insurer in the policy.
5. Artificial limbs or eyes, casts, splints, trusses or braces.
6. Treatment for functional nervous disorders, and mental and emotional disorders.
7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(5)*"a"* may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(5)*"a"*(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(6) *Individual basic medical expense coverage.*

a. "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 10 percent of the aggregate maximum limit under the policy for each covered person for at least:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed upon by the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(7) Not fewer than three days of the following additional benefits:

1. In-hospital private duty registered nurse services;
2. Convalescent nursing home care;
3. Diagnosis and treatment by a radiologist or physiotherapist;
4. Rental of special medical equipment, as defined by the insurer in the policy;
5. Artificial limbs or eyes, casts, splints, trusses or braces;
6. Treatment for functional nervous disorders, and mental and emotional disorders; or
7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(6)*"a"* may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(6)*"a"*(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as

determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed upon by the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(7) *"Disability income protection coverage"* is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them which:

a. Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

b. Contains an elimination period no greater than:

(1) Ninety days in the case of a coverage providing a benefit of one year or less;

(2) One hundred eighty days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(3) Three hundred sixty-five days in all other cases during the continuance of disability resulting from sickness or injury; and

c. Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy or childbirth in which case the period for disability may be one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period.

If a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

Subrule 36.6(7) does not apply to those policies providing business buy-out coverage.

36.6(8) *"Accident only coverage"* is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000 and a single dismemberment amount shall be at least $500.

36.6(9) *Specified disease and specified accident coverage.*

a. "Specified disease coverage" is a policy which meets one of the following definitions:

(1) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount, if any, not in excess of $250 and an overall aggregate benefit limit of not less than $5,000 and a benefit period of not less than two years for at least the following incurred expenses:

1. Hospital room and board and any other hospital-furnished medical services or supplies;
2. Treatment by a legally qualified physician or surgeon;
3. Private duty services of a registered nurse (R.N.);
4. X-ray, radium and other therapy procedures used in diagnosis and treatment;
5. Professional ambulance for local service to or from a local hospital;
6. Blood transfusions, including expense incurred for blood donors;
7. Drugs and medicines prescribed by a physician;
8. The rental of a respirator or similar mechanical apparatus;
9. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
10. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
11. May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(2) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $25,000 payable at the rate of not less than $50 a day while confined in a hospital and a benefit period of not less than 500 days.

b. "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for

accidental death or accidental death and dismemberment, combined with a benefit amount not less than $5,000 for accidental death, $5,000 for double dismemberment, and $2,500 for single dismemberment.

36.6(10) *"Limited benefit health insurance coverage"* is any policy or contract which provides benefits that are less than the minimum standards for benefits required under 36.6(2) to 36.6(8). Limited benefit policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by 36.7(12) is completed and delivered as required by 36.7(2). A policy covering a specified disease or combination of diseases shall meet the requirements of 36.6(9) and shall not be offered for sale as a "limited coverage." A policy which is designed to supplement Medicare shall meet the requirements of 191—Chapter 37 and shall not be offered for sale as a "limited coverage."

36.6(11) *Short-term limited-duration insurance coverage.*

a. "Short-term limited-duration insurance coverage" provides coverage up to an aggregate maximum of not less than $500,000 for each initial or renewal policy term and shall include a minimum of all of the following services subject to the approved policy terms, limitations and exclusions:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(2) Miscellaneous hospital services, including emergency room services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care consisting of physicians' services rendered on an ambulatory basis, and through telemedicine by remote diagnosis and treatment of patients by means of telecommunications technology, where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

(7) In-hospital registered nurse services;

(8) Convalescent nursing care;

(9) Diagnosis and treatment by a radiologist or physiotherapist;

(10) Rental of special medical equipment, as defined by the insurer in the policy;

(11) Artificial limbs or eyes, casts, splints, trusses or braces;

(12) Treatment for functional nervous disorders, mental and emotional disorders and substance use disorders; and

(13) Out-of-hospital prescription drugs and medications.

b. If the short-term limited-duration insurance coverage establishes a separate out-of-pocket maximum for the prescription drug benefit, the short-term limited-duration insurance coverage shall contain a deductible, coinsurance and copayment out-of-pocket maximum for all benefits for each covered person, excluding prescription drug services, that shall not exceed $5,000 multiplied by the number of months of coverage and not in excess of $20,000 for the full policy term of any duration, and the separate prescription drug benefit shall have a deductible, coinsurance and copayment out-of-pocket maximum separate from the other required services that shall not exceed $2,500 multiplied by the number of months of coverage and not in excess of $10,000 for the full policy term of any duration.

c. If the short-term limited-duration insurance coverage integrates a prescription drug benefit into the plan design, the deductible, coinsurance and copayment out-of-pocket maximum for each covered person for all medical and prescription drug coverage shall not exceed $7,500 multiplied by the number of months of coverage and not in excess of $30,000 for the full policy term of any duration.

d. After 180 days of coverage, short-term limited-duration insurance coverage that has an initial policy term or has been renewed or extended beyond 180 days in duration shall also provide preventative and wellness services subject to deductibles, coinsurance and copayments, including annual routine office visits, immunizations, mammography examinations, prostate-specific antigen blood tests and Papanicolaou tests.

e. Short-term limited-duration insurance shall not contain preexisting condition exclusions that exceed the initial policy term. Any renewable short-term limited-duration insurance shall be guaranteed renewable.

f. Short-term limited-duration insurance shall have an expiration date specified in the policy.

g. All short-term limited-duration policies shall contain the notices required of short-term limited-duration insurance as set forth in the Public Health Service Act, 45 CFR Section 144.103.

h. All short-term limited-duration insurance shall contain a free-look period of not less than ten days after the insured receives the policy during which the insured may cancel the insurance. If the insurance is so canceled, all fees and premiums paid shall be promptly refunded and the insurance shall be voided as if the policy had not been issued. Notice of the free-look period shall be prominently displayed on the first page of the policy.

(1) For the purposes of this paragraph, the policy shall be determined to be received by the insured as follows:

1. Pursuant to Iowa Code section 554D.117 if received electronically; and
2. Four days after the policy is postmarked for delivery if sent in the mail.

(2) For the purposes of this paragraph, the insured may cancel the insurance by giving notice to the insurance company, agent, broker or other representative in any manner, including but not limited to via electronic notice or by telephone.

i. All applications for short-term limited-duration insurance shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and identify any preexisting conditions.

This rule is intended to implement Iowa Code section 514D.4.

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