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The Iowa Administrative Code (IAC) Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement is a compilation of updated Iowa Administrative Code chapters that reflect rule changes which have been adopted by agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17, 17A.4, and 17A.5 and published in the Iowa Administrative Bulletin bearing the same publication date as the one for this Supplement. To determine the specific changes to the rules, refer to the Iowa Administrative Bulletin. To maintain a loose-leaf set of the IAC, insert the chapters according to the instructions included in the Supplement.

In addition to the rule changes adopted by agencies, the chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.8(9) or 17A.8(10); rescission of a rule by the Governor pursuant to section 17A.4(8); nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa; other action relating to rules enacted by the General Assembly; updated chapters for the Uniform Rules on Agency Procedure; or an editorial change to a rule by the Administrative Code Editor pursuant to Iowa Code section 2B.13(2).

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone 515.281.3355 or 515.242.6873

Commerce Department[181]

Remove Analysis and Chapter 1

Insurance and Financial Services Department[181]

Insert Analysis and Chapter 1

Insurance Division[191]

Replace Analysis
Replace Chapters 1 to 4
Replace Chapters 14 to 16
Replace Chapters 20 and 21
Replace Chapter 25
Replace Chapter 60
Replace Chapter 90

Educational Examiners Board[282]

Replace Analysis
Replace Chapters 11 and 12

Medicine Board[653]

Replace Analysis
Replace Chapter 13

INSURANCE AND FINANCIAL SERVICES DEPARTMENT[181]

[Created by 2023 Iowa Acts, Senate File 514]
[Prior to 3/20/24, see Commerce Department[181]]

NOTE: For the rules of divisions under this Department "umbrella," see Banking Division[187], Credit Union Division[189], and Insurance Division[191]

CHAPTER 1
ORGANIZATION AND OPERATION

CHAPTER 1
ORGANIZATION AND OPERATION

181—1.1(546,17A) Purpose. This chapter describes the organization and operation of the department of insurance and financial services (department).
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.2(546,17A) Scope of rules. The rules for the department are promulgated under Iowa Code chapters 17A and 546 and shall apply to all matters before the department. No rule shall, in any way, relieve a person affected by or subject to these rules or any person affected by or subject to the rules promulgated by the various divisions of the department from any duty under the laws of this state.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.3(546,17A) Duties of the department. The department administers and coordinates the various regulatory, service, and licensing functions of the state relating to the conducting of business or commerce in the state. The department consists of the following divisions: banking, credit union, and insurance.

1.3(1) *Banking division.* The banking division regulates and supervises state banks, regulated loan companies, industrial loan companies, mortgage bankers, mortgage brokers, real estate closing agents, debt management companies, money services companies, and delayed deposit service businesses and performs other duties assigned to it by law.

1.3(2) *Credit union division.* The credit union division regulates and supervises the operation of credit unions within the state; the credit union review board performs duties assigned to it by Iowa Code chapter 533.

1.3(3) *Insurance division.* The insurance division regulates and supervises the conduct of the business of insurance within the state and enforces the laws promulgated under Title XIII of the Iowa Code and Iowa Code chapters 502, 502A, 505, 505A through 523A, 523C, 523D, and 523I. The division performs other duties assigned to it by law.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.4(546,17A) Definitions.

"Administrator" means the commissioner of insurance, the superintendent of banking, or the superintendent of credit unions.

"Commissioner of insurance" means the same as defined in Iowa Code section 505.2.

"Department" means the department of insurance and financial services.

"Person" means an individual, corporation, partnership, association, professional corporation, licensee or permittee.

"Superintendent of banking" means the same as defined in Iowa Code section 524.201.

"Superintendent of credit unions" means the same as defined in Iowa Code section 533.104.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.5(546,17A) Central offices and communications. Correspondence and communications with the department shall be addressed or directed to the department's director. The department director is the commissioner of insurance. The department's website is iowa.gov/difs.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.6(546,17A) Custodians of records, filings and requests for public information. Unless otherwise specified by the department or the rules of its various divisions, each division is the principal custodian of its own divisional orders, statements of law or policy issued by the respective divisions, legal documents and other public documents on file with the department or its respective divisions. This is true in particular for the Iowa fair information practices Act. The responsibility for complying with that Act shall be upon the individual divisions. Each division shall promulgate rules pursuant to Iowa Code chapter 17A governing the manner in which documents may be filed with the respective divisions.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.7(546,17A) Division administrators' responsibilities.

1.7(1) *Rulemaking.* Each division administrator has the authority to promulgate rules pursuant to Iowa Code chapter 17A to implement the duties of the division. Such rules are not subject to review by the department director. All applicable rules previously promulgated by the divisions shall remain in effect until amended by the divisions.

1.7(2) *Decision making.* Decisions of the division administrator with respect to duties assigned to the division under the law are final agency actions pursuant to Iowa Code chapter 17A. Decisions by either the commissions or division administrators are not subject to review by the department director.

1.7(3) *Supervision.* Each division administrator has the authority to hire, allocate, develop, and direct employees and other resources assigned to the division by law.

1.7(4) *Establish fees.* Each division administrator has the authority to establish fees assessed to the regulated industry. The fees so established are not reviewable by the department director.

1.7(5) *Expenditure authorization.* Each division administrator may authorize expenditures from accounts for that division or office within the department of commerce revolving fund established in Iowa Code section 546.12, or otherwise use funds as permitted by Iowa Code section 546.12.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.8(17A) Petitions for rulemaking—uniform rules adopted. The department hereby adopts the Uniform Rules on Agency Procedure relating to petitions for rulemaking, which are published on the general assembly's website at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf, as rules 181—1.9(17A) to 181—1.12(17A) below, with amendments and exceptions specified therein.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.9(17A) Petition for rulemaking. Rule X.1 is adopted by reference with the following amendments: Any person or agency may file a petition for rulemaking with the respective division at the address disclosed on the department's website. A petition is deemed filed when it is received. The respective division must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the respective division an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.10(17A) Briefs. Rule X.2 is adopted by reference.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.11(17A) Inquiries. Rule X.3 is adopted by reference.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

181—1.12(17A) Agency consideration. Rule X.4 is adopted by reference.
[**ARC 7728C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code sections 17A.3 and 546.2.

[Filed emergency 7/1/86—published 7/30/86, effective 7/1/86]
[Filed 9/22/86, Notice 7/30/86—published 10/8/86, effective 11/12/86]
[Filed 3/4/88, Notice 10/21/87—published 3/23/88, effective 4/27/88]
[Filed emergency 11/4/94—published 11/23/94, effective 11/4/94]
[Filed ARC 2650C (Notice ARC 2575C, IAB 6/8/16), IAB 8/3/16, effective 9/7/16]
[Filed ARC 7728C (Notice ARC 7343C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

INSURANCE DIVISION[191]

[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the "umbrella" of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

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ORGANIZATION AND PROCEDURES

CHAPTER 1
ORGANIZATION

[Prior to 10/22/86, Insurance Department[510]]

191—1.1(502,505) Definitions. For rules of the insurance division, the following definitions apply:

"Commissioner" means the commissioner of insurance or the commissioner's designee.

"Division" means the Iowa insurance division.

"Division's website" means the information and related content found at iid.iowa.gov.

[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.2(502,505) Mission. The division protects consumers through consumer education and enforcement while effectively and efficiently providing a fair, flexible, and positive regulatory environment.

[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.3(502,505) General course and method of operations. The division is the state regulator that supervises all insurance business transacted in the state of Iowa as well as securities and other regulated industries.

[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.4(502,505) Contact information and business hours. The division's office and mailing address is 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. The general telephone number for the division is 515.654.6600 or 1.877.955.1212. The division's facsimile number is 515.654.6500. The division's website address is iid.iowa.gov. The division's hours are 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays.

[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.5(502,505) Information, forms, and requests. Information, applications, and forms may be obtained from the division's website, in person at the division's offices, or by telephone using the division's general telephone number. Specific instructions, forms and guidance may be provided in administrative rules or on the division's website. Submissions and requests can be submitted through the division's website, in person, or by telephone.

[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.6(502,505) Organization. The division is headed by the commissioner, who is assisted by a first deputy commissioner, a second deputy commissioner, a deputy commissioner for supervision, and other deputy commissioners and assistant commissioners. The functions of the division are divided into eight bureaus.

1.6(1) *Administrative bureau.* The administrative bureau provides staff support to the commissioner and the division and is responsible for budget, personnel, procurement, communication, legislative, and other services.

1.6(2) *Company regulation bureau.* The company regulation bureau is responsible for the following:

a. Regulating domestic and foreign insurance companies licensed in Iowa, through licensure, analysis and financial and market examinations.

b. Examining the financial condition of domestic insurance companies not less than once every five years. Foreign companies are examined as deemed appropriate. The bureau ensures compliance with National Association of Insurance Commissioners accreditation mandates and with financial examination and analysis standards.

c. Serving as a general insurance information repository and resource for both insurers and consumers and publishing the division's annual report to the governor, required by Iowa Code section 505.12.

d. Reviewing and approving filed company transactions, including but not limited to approval of acquisitions and mergers of domestic insurers, intercompany contractual agreements and assumption reinsurance agreements.

e. Authorizing and overseeing individual and group workers' compensation self-insurance.

f. Authorizing, examining and analyzing benevolent associations and fraternal benefit societies.

g. Authorizing and reviewing multiple employer welfare arrangements.

h. Registering and verifying compliance for risk retention groups.

i. Supervising the rehabilitation and liquidation of insurance companies.

j. Auditing and monitoring premium tax remittances for admitted companies and supervising statutory deposits.

k. Reviewing and approving admission applications for foreign surplus lines insurers, as well as conducting premium tax audits associated with the nonadmitted insurance industry.

l. Implementing and maintaining the division's information technology resources.

1.6(3) *Securities and regulated industries bureau.* The securities and regulated industries bureau is responsible for administering and enforcing the Iowa uniform securities Act through enforcement, licensing, and securities registration to ensure investor protection and a positive climate for capital formation. The bureau is also responsible for protecting the public by administering and enforcing rules related to motor vehicle service contracts, residential service contracts, retirement facilities, cemeteries, and preneed purchase agreements for cemetery merchandise, funeral merchandise and funeral services.

1.6(4) *Consumer advocate bureau.* The consumer advocate bureau consists of the consumer advocate and, in addition to being responsible for the duties described in Iowa Code section 505.8(6)*"b,"* is responsible for providing outreach to consumers, assisting in creation of consumer protection laws and regulations, and reviewing complaints. In order to fulfill the prescribed duties, the commissioner has delegated investigation and enforcement duties to the market regulation, enforcement, and fraud bureaus.

1.6(5) *Market regulation bureau.* The market regulation bureau is responsible for the following:

a. Ensuring fair treatment of consumers.

b. Investigating unfair or deceptive trade practices in the business of insurance.

c. Reviewing, investigating and responding to inquiries and complaints from the public regarding insurance producers and insurers.

d. When requested by consumers, coordinating external reviews of health insurance claim decisions if insurance companies deny benefits either on the basis that the services were not medically necessary or on the basis that the services were investigational or experimental.

e. When requested by consumers, coordinating independent reviews of long-term care insurance claim decisions if insurance companies deny benefits on the basis that insureds did not meet benefit trigger requirements.

1.6(6) *Enforcement bureau.* The enforcement bureau takes administrative action against individuals and entities regulated by the division for violations of insurance, securities, and other laws under the authority of the division and provides legal counsel to the division.

1.6(7) *Fraud bureau.* The fraud bureau confronts the problem of insurance and securities fraud by prevention, investigation, and prosecution of fraudulent insurance acts in an effort to reduce the amount of premium dollars used to pay fraudulent insurance claims, as set forth in Iowa Code chapter 507E, and may refer such matters to the appropriate jurisdiction for action or prosecution.

1.6(8) *Product and producer regulation bureau.* The product and producer regulation bureau is responsible for the following:

a. Reviewing, approving or disapproving property, casualty, life and health forms and, where provided by law, premium rates of certain types of insurance.

b. Performing actuarial analysis of life and health insurance plans funded by certain public bodies.

c. Licensing, registering, and monitoring entities and individuals under the authority of the commissioner.

d. Overseeing the senior health insurance information program (SHIIP) and senior Medicare patrol (SMP) and other Medicare beneficiaries and their families and caregivers. These programs include

providing information needed to make informed decisions about care and benefits; accessing financial assistance to cover related costs; and preventing Medicare fraud, errors and abuse.
[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

191—1.7(505) Service of process. Certain individuals and entities under the jurisdiction of the commissioner are required by law to consent to having the commissioner serve as agent for the individual or entity for the purpose of receiving service of process.

1.7(1) *Request for service.* A party to a proceeding who requests that the commissioner accept service of process as allowed by law must submit to the division, at the address stated in rule 191—1.4(502,505), all of the following:

a. For each individual or entity to be served, one original and one copy of the documents to be served by the division.

b. A cover letter indicating the name of each individual or entity to be served by the division.

c. A check for service fees, made payable to Iowa Insurance Division, for $50 for each individual or entity to be served, unless another amount is required by law.

1.7(2) *Division actions.* After the division receives the items listed in paragraph 1.7(1)*"a,"* the division must do the following:

a. Accept the service of process on behalf of the individual or entity.

b. Forward, by certified mail, the original documents to the individual or entity to be served.

c. File a notice of acceptance electronically through the Iowa court electronic filing system.

1.7(3) *Types of documents the division will serve.*

a. The division will serve documents related to the initiation of a case, such as original notices, petitions, and jury demands. The division will not serve documents related to later processes in a case, including but not limited to subpoenas and garnishments, unless required to do so by law.

b. The division will serve documents related to matters in the Iowa court system. The division will not serve documents related to matters in other courts, including but not limited to the federal court system, or matters in other administrative systems, except for workers' compensation cases filed with the Iowa division of workers' compensation.
[**ARC 7729C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code sections 17A.3, 502.601, 502.605, 505.1 and 505.30.

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]
[Editorial change: IAC Supplement 9/23/20]
[Filed ARC 7729C (Notice ARC 7344C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

CHAPTER 2
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

191—2.1(17A,22) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound division determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This division is committed to the policies set forth in Iowa Code chapter 22. The division's website provides access to all public records. Division staff will cooperate with members of the public in implementing the provisions of that chapter.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.2(17A,22) Definitions. The definitions in Iowa Code section 22.1 are incorporated into this chapter by this reference. In addition to the definitions in rule 191—1.1(502,505), the following definitions apply:

"Confidential record" means a record that is not available as a matter of right for inspection and copying by members of the public under applicable provisions of law. Confidential records may be specified as confidential by Iowa Code section 22.7 or other provisions of law but may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Division" means the insurance division of the department of insurance and financial services created by Iowa Code section 505.1. The division is both the "government body" and the "lawful custodian" as defined in Iowa Code sections 22.1(1) and 22.1(2), respectively. The division is also the "agency" as defined in Iowa Code chapter 17A and referenced in Iowa Code chapter 22. For purposes of this chapter, "division" includes both the commissioner of insurance and the administrator as defined in Iowa Code chapters 502 and 505.

"File," "filed," or *"filing,"* when used as a verb, means submitting or having submitted to the division a record or information. "File" or "filing," when used as a noun, means a record or information.

"Inspect" or *"inspection"* means the same as "examine" or "examination" in Iowa Code chapter 22. The term "examination" in this chapter does not mean the same as "examination" as used in Iowa Code chapter 22.

"Lawful custodian," as used in Iowa Code section 22.1(2), is the division, the division's record officer, or an employee lawfully delegated authority by the division to act for the division in implementing Iowa Code chapter 22.

"Open record" means a record other than a confidential record.

"Personally identifiable information" means information about or pertaining to an individual in a record that identifies the individual and that is contained in a record system.

"Record" means all or part of a "public record," as defined in Iowa Code section 22.1, that is owned by or in the physical possession of the division.

"Record system" means any group of records under the control of the division from which a record may be retrieved by a personal identifier.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.3(17A,22) General provisions.

2.3(1) *Entities holding division records covered by this rule.* This rule applies to records belonging to, required by, or created by the division, as well as records held by third parties, including other state agencies, that do any of the following:

a. Perform division functions on behalf of the division;

b. Store records for the division;

c. Perform services for the division; or

d. Otherwise handle records that would be governed by this rule if they were in the possession of the division.

2.3(2) *Existing records.* A request for access shall apply only to records that exist at the time the request is made and access is provided. The division is not required to create, compile or procure a record solely for the purpose of making it available except as described in Iowa Code section 22.3A and subrule 2.4(5).

2.3(3) *Public records.* All of the division's records are open records available to the public except for records that are confidential under rule 191—2.12(17A,22) or redactable under rule 191—2.11(17A,22).

2.3(4) *Availability of open records.* Open records of the division are available to the public for examination and copying unless otherwise provided by state or federal law, regulation or rule.

2.3(5) *Office hours.* Open records are available for inspection during customary office hours, which are 8 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays.

2.3(6) *Scope.* This chapter does not:

a. Require the division to index or retrieve records that contain information about individuals by that person's name or other personal identifier.

b. Make available to the general public records that would otherwise not be available under the public records law, Iowa Code chapter 22.

c. Govern the maintenance or disclosure of, notification of or access to records in the possession of the division that are governed by the regulations of another agency.

d. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs.

e. Make available records compiled in reasonable anticipation of court litigation or formal administrative proceedings.

f. Make any warranty of the accuracy or completeness of a record.

[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.4(17A,22) Requests for access to records.

2.4(1) *Request for access.* Requests for access to open records not available on the division's website may be made in writing, by mail, by email, or online as instructed on the division's website. Requests must identify the particular records sought by name or description in order to facilitate the location of the record. Requests must include the name, address, email address if available, and telephone number of the person requesting the information. A person is not required to give a reason for requesting an open record. If the division has records in its possession that may be public records but that are copies of materials from another agency or public organization, the division may refer individuals to the originating agency or entity.

2.4(2) *Response to requests.*

a. Access. Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the division must comply with the request as soon as feasible.

b. Delay. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4), for redaction by the division of confidential information, or for search and review of requested records. The division must promptly give written notice to the requester of the reason for any delay and an estimate of the length of that delay.

c. Deny. The division may deny access to the record by members of the public when warranted under Iowa Code chapter 22 or other applicable law or when the record's disclosure is prohibited by a court order.

2.4(3) *Security of record.* No person may, without permission from the division, search or remove any record from division files. Inspection and copying of division records must be supervised by the division or a designee of the division in order for the records to be protected from damage and disorganization.

2.4(4) *Fees.* The division may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service, whether electronic or hard copy, or mailing shall not exceed the cost of providing the service. An hourly fee may be estimated in advance and charged for actual division expenses in the inspection, reviewing, and

copying of requested records when the total staff time dedicated to fulfilling the request requires an excess of two hours.

2.4(5) *Information released.* If a person is provided access to less than an entire record, the division shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released or a copy of the record from which the information not to be released has been otherwise redacted.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.5(17A,22) Access to confidential records.

2.5(1) *Procedure.* The following provisions are in addition to those specified in rule 191—2.4(17A,22) and are minimum requirements. A statute or another administrative rule may impose additional requirements for access to certain classes of confidential records. A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The division shall not refuse to release the nonconfidential information simply because of the manner in which the record is compiled or stored.

a. Form of request. The division shall ensure that there is sufficient information to provide reasonable assurance that access to a confidential record may be granted. Therefore, the division may require the requester to:

(1) Submit the request in writing.

(2) Provide proof of identity and authority to secure access to the record.

b. Response to request. The division must notify the requester of approval or denial of the request for access. The notice must include:

(1) The name and title or position of the person responding on behalf of the division; and

(2) A brief statement of the grounds for denial, including a citation to the applicable statute or other provision of law.

c. Reconsideration of denial. A requester whose request is denied by the division may apply to the commissioner of insurance for reconsideration of the request.

2.5(2) *Release of confidential records by the division.* The division may release a confidential record or a portion of it to:

a. The legislative services agency pursuant to Iowa Code section 2A.3.

b. The ombudsman pursuant to Iowa Code section 2C.9.

c. Other governmental officials and employees only as needed to enable them to discharge their duties.

d. The public information board pursuant to Iowa Code section 23.6.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.6(17A,22) Requests for confidential treatment. The division may treat a record as a confidential record and withhold it from inspection or refuse to disclose that record to members of the public only to the extent that the division is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order. All other information submitted to the division shall be treated as if that person has no objection to its disclosure to members of the public.

2.6(1) *Request.* A person may request that all or a portion of a record be confidential. The request for confidential treatment must be submitted in writing to the division and:

a. Identify the information for which confidential treatment is sought.

b. Cite the legal and factual basis that justifies confidential treatment.

c. Identify the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request.

d. Specify the precise period of time for which the confidential treatment is requested should the request be only for a limited time period.

2.6(2) *Additional information.* The division may request additional factual information from the person to justify treatment of the record as a confidential record.

2.6(3) *Decision.* The division must notify the requester in writing of the granting or denial of the request and, if the request is denied, the reasoning for the denial.

2.6(4) *Request denied.* If the request for confidential treatment of a record is denied, the requester may apply to the commissioner for reconsideration of the request.

2.6(5) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the division from treating it as a confidential record.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.7(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the division. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any division proceeding.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.8(17A,22) Disclosures without the consent of the subject.

2.8(1) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject.

2.8(2) Authority to release confidential records. The division may have discretion to disclose some confidential records that are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect these records withheld from inspection under a statute that authorizes limited or discretionary disclosure as provided in rule 191—2.6(17A,22). If the division initially determines that it will release such records, the division may notify interested persons and withhold the records from inspection as provided in rules 191—2.6(17A,22) and 191—2.7(17A,22).
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.9(17A,22) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record may consent to have a copy of the portion of that record that concerns the subject disclosed to a third party. A request for such a disclosure must be in writing, and the person to whom the record is to be disclosed may be required to provide proof of identity. Appearance of counsel before the division on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the division to disclose records about that person to the person's attorney.
[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.10(17A,22) Notice to suppliers of information. When the division requests a person to supply information about that person, the division must notify the person by reasonable means of the use that will be made of the information, which persons outside the division might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested.

2.10(1) *Notice.* The notice shall generally be given at the first contact with the division and need not be repeated. Where appropriate, the notice may be given to a person's legal or personal representative. Notice may be withheld in an emergency or when it would compromise the purpose of a department investigation.

2.10(2) *License and examination applicants.* License and examination applicants are requested to supply a wide range of information depending on the qualifications for licensure or sitting for an examination, as provided by division statutes, rules and application forms. Failure to provide requested information may result in denial of the application. Some requested information, such as social security numbers, home addresses, examination scores, and criminal histories, is confidential under state or federal law, but most of the information contained in license or examination applications is treated as public information and is freely available for public examination.

2.10(3) *License renewal.* Licensees are requested to supply a wide range of information in connection with license renewal, both on paper and electronically. Failure to provide requested

information may result in denial of the application. Most information contained on renewal applications is treated as public information freely available for public examination, but some information may be confidential under state or federal law.

2.10(4) *Investigations.* Persons and entities regulated by the division are required to respond to division requests for information as part of the investigation of a complaint or inquiry. Failure to timely respond may result in disciplinary action against the person or entity to which the request is made. Information provided in response to such a request is confidential pursuant to the Iowa Code, including but not limited to Iowa Code sections 502.607(2), 505.8(8)*"a,"*507E.5, and 523A.803, but may become public if introduced at a hearing that is open to the public, contained in a final order, or filed with a court of judicial review.

2.10(5) *Discovery request, subpoenas, and investigations.* Notice need not be given in connection with discovery requests in litigation or administrative proceedings, subpoenas, investigations of possible violations of law or similar demands for information.

2.10(6) *Other requested information.* In general, pursuant to state or federal law, the division requests information necessary for its regulation of insurance, securities, and regulated industries that is required to be provided to the division. This required information may be shared outside the division when required by state or federal law or division rules. Failure of a regulated entity or person to provide this information may result in the denial of the licensure or regulatory approval, as appropriate, for which the information was requested.

[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.11(17A,22) Personally identifiable information collected by the division. The division collects and maintains open records, some of which may contain personally identifiable information, and some of which may be shared with other state or federal agencies or organizations or vendors. This rule describes the nature and extent of personally identifiable information that is collected, maintained, and retrieved by the division. Unless otherwise stated, the authority for the collection of the record is provided by Iowa Code chapter 502 or 505. Some personally identifiable information is protected by Iowa Code sections 502.607(2)*"e"* and 505.8(9).

2.11(1) *Nature and extent.* The following records may contain personally identifiable information:

a. Confidential records. Records listed as confidential records are described in rule 191—2.12(17A,22).

b. Rulemaking records. Rulemaking records may contain information about people who make written or oral comments about proposed rules.

c. Contested case records. Contested case records contain names and identifying numbers of people involved. Evidence and documents submitted as a result of a contested case are contained in contested case records.

d. Licensing records. Licensing records of individuals and entities regulated by the division contain names and identifying numbers of the regulated individual or individuals designated as responsible for the regulated entity.

e. Complaint, inquiry, investigation, and examination records. Complaint, inquiry, investigation, and examination records contain names and identifying numbers of the people who submit, are the subject of, or are otherwise involved in the complaint, inquiry, investigation or examination.

f. Personnel files. The division maintains files containing information about employees of the division and applicants for positions with the division.

2.11(2) *Redaction.* To the extent that the division finds it necessary to allow inspection of records containing personally identifiable information, the division must, when allowed by law, redact the personally identifiable information prior to allowing the inspection.

2.11(3) *Means of storage.* Paper and various electronic means of storage are used to store records containing personally identifiable information.

[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

191—2.12(17A,22) Confidential records. This rule describes the types of agency information or records that are confidential. This rule is not exhaustive. The following records shall be kept confidential.

2.12(1) Records that are exempt from disclosure under Iowa Code section 22.7.

2.12(2) Records that constitute attorney work product or attorney-client communications, or that are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11; Iowa R.C.P. 122(c); Fed. R. Civ. P. 26(b)(3); and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.

2.12(3) Those portions of the division's staff manuals, instructions or other statements issued by the division that set forth criteria or guidelines to be used by division staff in auditing, making inspections, settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when the disclosure of such statements would enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the division, pursuant to Iowa Code sections 17A.2 and 17A.3.

2.12(4) All information obtained and prepared in the course of an inquiry, complaint, or investigation, including but not limited to communications, insurer documents, data, reports, analysis, and notes, pursuant to Iowa Code section 505.8 and chapters 502, 502A, 505, 507A, 507E, 522B, 523C, and 523I.

2.12(5) Information of insurers designated as confidential by applicable law, including but not limited to information and reports that are part of an examination, pursuant to Iowa Code sections 505.17 and 507.14.

2.12(6) Information of the Iowa life and health guaranty association, pursuant to Iowa Code chapters 508C and 515B.

2.12(7) Insurance holding company systems registration and holding company examinations, pursuant to Iowa Code section 522.7.

2.12(8) Information related to the uniform securities Act that is designated nonpublic pursuant to Iowa Code section 502.607.

2.12(9) Information filed with the division related to preneed sellers and sales agents of cemetery and funeral merchandise and funeral services pursuant to Iowa Code chapter 523A.

2.12(10) Information obtained in the course of an examination of a cemetery pursuant to Iowa Code chapter 523I.

2.12(11) All records relating to prearranged funeral contracts, except upon approval by the commissioner of insurance or the attorney general, pursuant to Iowa Code section 523A.204(3).

2.12(12) Identifying details in final orders, decisions, and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1)*"e."*

2.12(13) Sealed bids received prior to the time set for public opening of bids, pursuant to Iowa Code section 72.3.

2.12(14) Information related to external review of health care coverage decisions, pursuant to Iowa Code chapter 514J.

2.12(15) Information related to automobile insurance cancellation, pursuant to Iowa Code chapter 515D.

2.12(16) Determination of any suspension of an insurance producer's or other licensee's pending application for licensure, pending request for renewal, or current license, when the suspension is related to failure to pay child support, foster care, or state debt, pursuant to rule 191—10.21(252J).

2.12(17) All other information or records that by law are or may be confidential.

[**ARC 7730C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code section 22.11.

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]
[Filed ARC 4949C (Notice ARC 4840C, IAB 1/1/20), IAB 2/26/20, effective 4/1/20]
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[Filed ARC 7730C (Notice ARC 7345C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

CHAPTER 3
CONTESTED CASES
[Prior to 10/22/86, Insurance Department[510]]

191—3.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the insurance division.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.2(17A) Definitions. In addition to the definitions in rule 191—1.1(502,505), and except where otherwise specifically defined by law or the context otherwise requires, the following definitions apply:

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

"File," "filed," or *"filing,"* when used as a verb, means the actions set forth in subrules 3.12(3) and 3.12(4), except otherwise specifically defined by law. "Filing," when used as a noun, means the documents filed.

"Issuance" means the date of mailing of a decision or order or the date of delivery if service is by other means, unless another date is specified in the order.

"License" means the whole or a part of any permit, certificate, approval, registration, charter or similar form of permission required by statute.

"Licensee" means a person or entity to whom the division has issued a license.

"Party" means the same as defined in Iowa Code section 17A.2.

"Person" means the same as defined in Iowa Code section 17A.2.

"Presiding officer" means the commissioner, the commissioner's designee or an administrative law judge from the department of inspections, appeals, and licensing.

"Proposed decision" means the administrative law judge's or the commissioner's designee's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the commissioner did not preside.

"Provision of law" means the same as defined in Iowa Code section 17A.2.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.3(17A) Time requirements.

3.3(1) Time shall be computed as provided in Iowa Code section 4.1(34).

3.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer may afford all parties an opportunity to be heard or to file written arguments.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.4(17A) Requests for contested case proceeding. Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the division action in question. The request shall be filed with the division at the address disclosed in rule 191—1.4(502,505).

The request for a contested case proceeding shall state the name and address of the requester; identify the specific division action that is disputed if applicable; include a short and plain statement of the issues of material fact in dispute; and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing a contested case proceeding in the particular circumstances involved.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.5(17A,507B) Commencement of hearing; service; delivery; notice of hearing; answer.

3.5(1) *Service and delivery of the notice of hearing.*

a. Commencement of hearing. Delivery of the notice of hearing referred to in this rule constitutes commencement of the contested case proceeding.

b. Delivery of the notice of hearing. Delivery shall be accomplished by personal service as provided in the Iowa Rules of Civil Procedure or by certified mail, return receipt requested, at least 15 days before the hearing date unless the parties agree to a shorter time period, or unless otherwise provided by statute. Proof of delivery by mail is the same as proof of mailing specified in subrule 3.12(5).

c. Consent to service upon the commissioner. For persons who have consented in writing to have the commissioner accept service of process on their behalf, delivery of the notice of hearing referred to in this rule is accomplished at the time the notice of hearing is signed by the commissioner, unless otherwise provided by law.

3.5(2) *Notice of hearing.* The notice of hearing shall be prepared in the form of an order and contain the following information in the notice of hearing or accompanying charging document:

a. A statement of the time, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the particular sections of the statutes and rules involved;

d. A short and plain statement of the matters asserted. If the division or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon written application, a more definite and detailed statement shall be furnished;

e. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the division and of parties' counsel where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Reference to the procedural rules governing settlement;

h. Identification of the presiding officer and address, if known. If not known, a general description of the type of person who will serve as presiding officer;

i. Notification of the time period in which a party may request, under rule 191—3.6(17A), that the presiding officer be an administrative law judge;

j. Notification that failure to file an answer within 20 days of service may result in default pursuant to rule 191—3.22(17A); and

k. Reference to the procedural rules governing discovery.

3.5(3) *Answer.* An answer shall be filed within 20 days of service of the notice of hearing unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement of the matters asserted or charging document when appropriate.

a. An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the notice of hearing or accompanying charging document. The answer shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

b. An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

c. Any allegation in the notice of hearing or accompanying charging document not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer that could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

d. The answer shall be filed with the division pursuant to rule 191—3.12(17A).

3.5(4) *Amendments.* Any notice of hearing or other charging document may be amended before a responsive pleading has been filed. Amendments to a notice of hearing or charging document after a responsive pleading has been filed and amendments to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

3.5(5) *Timing of hearing.* The hearing in a contested case proceeding shall be held within 90 days after the commencement of the contested case unless a continuance is granted by the presiding officer.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.6(17A) Presiding officer.

3.6(1) If the presiding officer is not an administrative law judge, any party wishing to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections, appeals, and licensing must file a written request with the division within 20 days after service of a notice of hearing identifying or describing the presiding officer as the commissioner or commissioner's designee.

3.6(2) The commissioner may deny the request only upon a finding that one or more of the following apply:

a. Neither the commissioner nor any designee under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.

b. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.

c. An administrative law judge with the qualifications identified in subrule 3.6(4) is unavailable to hear the case within a reasonable time.

d. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

e. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

f. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.

g. The request was not timely filed.

h. The request is not consistent with a specified statute.

i. A statute requires the commissioner or designee to serve as presiding officer.

j. The contested case arises from matters asserted pursuant to Iowa Code chapter 507A, 507B, 508B, 515G or 521A.

3.6(3) The commissioner or designee shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 3.6(4), the parties shall be notified at least ten days prior to hearing if a qualified administrative law judge will not be available.

3.6(4) An administrative law judge assigned to act as presiding officer in insurance and securities matters shall be admitted to practice law before the courts of the state of Iowa.

3.6(5) Except as otherwise provided by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the commissioner. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.7(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the division may exercise discretion to refuse to give effect to such a waiver when the waiver is inconsistent with the public interest.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.8(17A) Telephone, video, or electronic proceedings.

3.8(1) The presiding officer may resolve preliminary procedural motions by telephone conference, videoconference or other electronic means in which all parties have been afforded notice and an opportunity to participate.

3.8(2) The presiding officer may, on the officer's own motion or as requested by a party, order hearings or argument to be held by telephone conference, videoconference or other electronic means in which all parties have an opportunity to participate. Any party may call witnesses by telephone conference, videoconference or other electronic means with 14 days' advance notice to all parties and the presiding officer. Failure of a party to make timely disclosure may result in the disallowance of testimony by telephone conference, videoconference or other electronic means.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.9(17A) Disqualification.

3.9(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

a. Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, another factually related contested case with common disputed facts, or a pending controversy with common disputed facts that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a factually related contested case with common disputed facts or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that is (1) a party to the case, or an officer, director or trustee of a party; (2) a lawyer in the case; (3) known to have an interest that could be substantially affected by the outcome of the case; or (4) likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in the case.

3.9(2) The term "personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information that is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter that culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 3.9(3) and 3.23(8).

3.9(3) In a situation where a presiding officer or other person knows of information that might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

3.9(4) To request disqualification of a presiding officer, a party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion shall be filed as soon as practical after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but shall establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party requesting disqualification may seek an interlocutory appeal under rule 191—3.25(17A) and seek a stay under rule 191—3.29(17A).

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.10(17A) Consolidation—severance.

3.10(1) The presiding officer may consolidate contested case proceedings where (a) the matters at issue involve common parties or common questions of fact or law, (b) consolidation would expedite and simplify consideration of the issues involved, and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

3.10(2) The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.11 Reserved.

191—3.12(17A) Service and filing of pleadings and other papers.

3.12(1) *Required service.* Every pleading, motion, document, or other paper that is filed in a contested case proceeding and every discovery request or response in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the division, no later than the time of filing, if filing is required. Except for an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

3.12(2) *Methods of service.* Service upon a party represented by an attorney shall be made upon the attorney of record unless otherwise ordered. Service is made by delivering or mailing a copy to the attorney at the attorney's last-known mailing address. Service upon an unrepresented party shall be made by delivering or mailing a copy to the party's last-known mailing address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order. Service may also be made upon a party or attorney by email if the party or attorney consents in writing to be served in that manner in that case. The party or attorney may consent by providing an email address for service to the other party or by filing a document with the division by email as specified in subrule 3.12(4). The consent may be withdrawn by written notice served on all other parties or attorneys. Service by electronic means is complete upon transmission to the provided email address unless the party making service received an electronic rejection or delivery failure.

3.12(3) *Required filing.* After the notice of hearing, all pleadings, motions, and notices of discovery in a contested case proceeding shall be filed with the division's designated filing clerk. If a contested case is assigned to an administrative law judge with the department of inspections, appeals, and licensing, filing shall be conducted in accordance with the rules of the department of inspections, appeals, and licensing, unless ordered otherwise.

3.12(4) *Methods of filing.* Except where otherwise provided by law, a document is deemed filed at the time it is hand-delivered to the division at the address disclosed in rule 191—1.4(502,505) during normal business hours, delivered to an established courier service for immediate delivery to that office during normal business hours, mailed by first-class mail or state interoffice mail to that office so long as there is proof of mailing, or emailed to the designated filing clerk at enforcement.filings@iid.iowa.gov.

3.12(5) *Proof of mailing and emailing.* Proof of mailing and emailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Insurance Division at the address disclosed in 191—1.4(502,505) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail). I emailed copies of (describe document) addressed to the Insurance Division at the email address disclosed in subrule 3.12(4) and to the names and email addresses of the parties listed below by transmitting the same from (sending email address).
>
> (Date) (Signature)

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.13(17A) Discovery.

3.13(1) *Discovery permitted.* Where statutory time limitations permit, discovery may be conducted as permitted by the Iowa Rules of Civil Procedure and these rules. Discovery shall be conducted in an expedited manner to prevent unnecessary delays to the hearing.

3.13(2) *Scope of discovery.* Parties may obtain discovery regarding any matter, not privileged or confidential, which is relevant to the claim or defense of the party in the pending action seeking discovery or to the claim or defense of any other party. Discovery responses are subject to the confidentiality provisions of Iowa Code section 22.7, chapters under the jurisdiction of the commissioner, and rule

191—3.12(17A), in accordance with applicable law, including, but not limited to, Iowa Code sections 17A.13(2) and 522B.11(6), unless otherwise permitted by the presiding officer for good cause shown.

3.13(3) *Notice of discovery.* Discovery is only permitted after a party has filed, pursuant to rule 191—3.12(17A), a notice of discovery no later than 15 days after the filing of an answer unless extended by the presiding officer for good cause shown or by agreement of the parties. The notice of discovery shall be a general notice that the party is serving discovery. The notice should include a statement regarding the type of discovery being conducted and the due date.

3.13(4) *Discovery responses.* Parties must respond to discovery within 15 days of receipt unless the parties mutually agree there is good cause to lengthen the response period or by order of the presiding officer. Time periods for compliance with discovery may be lengthened or shortened by order of the presiding officer.

3.13(5) *Discovery completion.* All discovery must be completed no later than 30 days before the prehearing conference.

3.13(6) *Discovery motions.* Any motion relating to discovery must allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party in a timely manner. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of any such motion unless the time is shortened as provided in subrule 3.13(4). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.14(17A,505) Subpoenas.

3.14(1) A subpoena shall be issued by the presiding officer at a party's request.

a. A request for a subpoena must be in writing and submitted to the presiding officer or designated filing clerk by mail, email, or in-person delivery in accordance with the filing requirements of rule 191—3.12(17A).

b. The request shall include the names of the parties, the case number, the name and address of the requested witness, and a description or list of any documents or other items requested. The request shall also note the nature of the proceeding at which the witness is requested to testify (e.g., deposition, telephone hearing, or in-person hearing), the date and time of the proceeding, whether the witness is requested to appear in person or by telephone, the location of the proceeding, and the method of recording any deposition.

c. In the absence of good cause for permitting later action, a request for a subpoena must be received at least ten days before the scheduled proceeding.

3.14(2) The requesting party is responsible for arranging service of a subpoena prior to the proceeding at which the testimony is commanded or the time at which the requested documents must be produced. The requesting party is responsible for any cost associated with serving a subpoena and for the payment of witness fees and mileage expenses. Subpoenaed witnesses shall be entitled to receive witness fees for attendance, paid pursuant to Iowa Code section 622.69, and mileage shall be paid for each mile actually traveled for a subpoenaed witness to participate in an in-person hearing or deposition pursuant to Iowa Code section 622.69. Witnesses called to testify only to an opinion founded on special study or experience in any branch of science, or to make scientific or professional examinations and state the result thereof, may receive additional compensation, to be fixed by the presiding officer, with reference to the value of the time employed and the degree of learning or skill required, but such additional compensation shall not exceed the sum set forth in Iowa Code section 622.72.

3.14(3) The presiding officer may quash or modify a subpoena upon motion as provided in the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be promptly set for hearing.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.15(17A) Motions.

3.15(1) No technical form for motions is required. However, prehearing motions must be in writing and must state the grounds for relief and relief sought.

3.15(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by the presiding officer. In ruling on a motion, the presiding officer may consider the motion unresisted, if no response is timely filed.

3.15(3) The presiding officer may schedule oral argument on any motion.

3.15(4) Motions pertaining to the hearing, except motions for summary judgment and requests for continuances, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by an order of the presiding officer.

3.15(5) Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment may be filed and served within a reasonable time prior to the hearing, as determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days from the date a copy of the motion was served unless otherwise ordered by the presiding officer. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to rule 191—3.28(17A) and appeal pursuant to rule 191—3.27(17A).

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.16(17A) Prehearing conference.

3.16(1) A prehearing conference shall be scheduled not less than seven business days prior to the hearing date. The presiding officer shall give written notice of the prehearing conference to all parties.

3.16(2) Prehearing conferences may be conducted by telephone conference or videoconference or in person as stated in the notice of hearing, unless otherwise ordered by the presiding officer.

3.16(3) Each party shall exchange and receive prior to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for failure to include their names; and

b. A final list and copies of exhibits that the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for failure to include them.

3.16(4) Witness or exhibit lists may be amended subsequent to the prehearing conference within time limits established by the presiding officer at the prehearing conference. If no time limits are established at the prehearing conference, subsequent amendments to a witness or exhibit list may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms and time limits. Any such amendments must be served on all parties.

3.16(5) In addition to the requirements of subrule 3.16(3), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters that the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters that will expedite the hearing.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.17(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

3.17(1) An application for a continuance shall:

a. Be made at the earliest possible time and no less than 14 days before the hearing except in case of unanticipated emergencies or consent of all parties, and

b. State the specific reasons for the request.

3.17(2) In determining whether to grant a continuance, the presiding officer may consider:

a. Prior continuances;
b. The interests of all parties;
c. The likelihood of informal settlement;
d. The existence of an emergency;
e. Any objection;
f. Any applicable time requirements;
g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
h. The timeliness of the request;
i. Failure to timely provide discovery responses; and
j. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.19(17A,507B) Intervention.

3.19(1) A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, including any statutory grounds, and the position and interest of the proposed intervenor. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

3.19(2) Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case.

3.19(3) The movant shall demonstrate that (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties; or (d) there exists a statutory right to intervene.

3.19(4) If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.20(17A) Hearing procedures.

3.20(1) The presiding officer presides at the hearing and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure orderly conduct of the proceedings.

3.20(2) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;
b. Parties shall be given an opportunity to present opening statements;
c. Parties shall present their cases in the sequence determined by the presiding officer;
d. Each witness shall be sworn or affirmed by the presiding officer, the court reporter, or a person otherwise authorized by law and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law; and
e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

3.20(3) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel a person whose conduct is disorderly.

3.20(4) Parties have the right to participate and to be represented by an attorney in all hearings or prehearing conferences related to their case. Any party may be represented by an attorney or another person authorized by law, subject to Iowa Court Rule 31.14.

3.20(5) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

3.20(6) All objections shall be timely made and stated on the record.

3.20(7) Witnesses may be sequestered during the hearing. This rule does not authorize exclusion of (1) a party who is a natural person, or (2) an officer or employee of a party that is not a natural person designated as its representative by its attorney, or (3) a person whose presence is shown by a party to be essential to presentation of the cause.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.21(17A,507B) Evidence.

3.21(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with applicable requirements of law.

3.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

3.21(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, may receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

3.21(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should be provided to opposing parties no later than the time they are proffered to the presiding officer. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

3.21(5) A party may object to specific evidence. A party may request limits on the scope of any examination or cross-examination. Objections shall be accompanied by a brief statement of the grounds upon which the objections are based. The objection and the ruling on the objection shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision, if appropriate.

3.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.22(17A) Default.

3.22(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice as provided in subrule 3.5(1), the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

3.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and failed to file a required pleading or has failed to appear after proper service.

3.22(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate constitute final division action unless one of the following occurs: (1) the presiding officer otherwise orders, (2) a motion to vacate the default decision is filed within 15 days after the date of

notification or mailing of the decision in accordance with rule 191—3.12(17A), or (3) an appeal to the commissioner of a proposed default decision is filed in accordance with rule 191—3.27(17A). A motion to vacate must be filed and served on all parties and state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

3.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

3.22(5) A motion to vacate shall be granted only when it is timely filed, is properly substantiated, and demonstrates good cause for the party's failure to appear or participate. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

3.22(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

3.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 191—3.25(17A).

3.22(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall schedule another hearing on the merits and the contested case shall proceed accordingly.

3.22(9) A default decision may award any relief authorized by statute or rule.

3.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 191—3.29(17A).

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.23(17A) Ex parte communication.

3.23(1) Unless required for the disposition of ex parte matters specifically, through communication either written, oral, or other forms authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the division or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 3.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

3.23(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

3.23(3) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 191—3.12(17A) and may be supplemented by telephone, facsimile, email or other means of notification.

3.23(4) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

3.23(5) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 191—3.16(17A).

3.23(6) A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record, either under seal by protective order or in the public file, at the discretion of the presiding officer. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

3.23(7) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery.

3.23(8) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the division. Violation of ex parte communication prohibitions by division personnel shall be reported to the first deputy commissioner or designee for possible sanctions including censure, suspension, dismissal or other disciplinary action.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.24(17A) Recording costs. Upon request, the presiding officer with notice to all parties shall provide a copy of the whole or any portion of the record at a reasonable cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party. Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the commissioner or designee may review an interlocutory order of the presiding officer. In determining whether to do so, the commissioner or designee shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order at the time the proposed decision of the presiding officer is reviewed would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.
[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.26(17A) Final decision.

3.26(1) When the commissioner presides over the reception of evidence at the hearing, the commissioner's decision is a final decision.

3.26(2) When the commissioner does not preside over the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the division when adopted by the commissioner or without further proceedings after the time provided in rule 191—3.27(17A) unless there is a timely appeal to the commissioner or motion by the division to review the proposed decision.

3.26(3) The presiding officer's decision shall specify in bold print either that the decision is final or that the decision shall become final without further proceedings after the time provided in rule 191—3.27(17A).

3.26(4) Any administrative law judge serving as a presiding officer in a contested case shall report to the commissioner on a monthly basis all matters taken under advisement for longer than 60 days, together with an explanation of the reasons for the delay and an expected date of a proposed decision. A matter shall be reported when all hearings have been completed and the matter awaits decision without further appearance of the parties or their attorneys, even though briefs or transcripts have been ordered but have not yet been filed. The report shall be due on the tenth day of each calendar month for the period ending with the last day of the preceding calendar month. The report shall be signed by the administrative law judge. All reports received will be filed with the Iowa insurance division as records available for public inspection.

3.26(5) Parties shall be promptly notified of each proposed or final decision or order by delivery to them of a copy of such decision or order in the manner provided by Iowa Code section 17A.12(1) unless the party has consented to an alternative form of delivery.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.27(17A) Appeals and review by the commissioner of proposed decisions.

3.27(1) Any adversely affected party may appeal a proposed decision to the commissioner within 30 days after issuance of the proposed decision.

3.27(2) The division may initiate review of a proposed decision on its own motion at any time within 30 days following issuance of such a decision.

3.27(3) An appeal of a proposed decision is initiated by filing a timely notice of appeal with the commissioner. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The proposed decision or order appealed from;

b. The parties initiating the appeal;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The grounds for relief; and

e. The relief sought.

3.27(4) On appeal from a proposed decision of a presiding officer, the issues shall be limited to those raised before the presiding officer. No new issues will be considered for the first time on appeal.

3.27(5) On appeal, a party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within ten days of service of the notice of appeal. The commissioner may remand a case to the presiding officer for further hearing or the commissioner may preside at the taking of additional evidence.

3.27(6) The commissioner shall issue a schedule for consideration of the appeal.

3.27(7) Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Any written requests to present oral argument shall be filed with the briefs. The commissioner may resolve the appeal on the briefs or provide an opportunity for oral argument. The commissioner may shorten or extend the briefing period as appropriate.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.28(17A) Applications for rehearing.

3.28(1) Any party to a contested case proceeding may file an application for rehearing from a final order.

3.28(2) The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires

reconsideration of all or part of the division decision on the existing record and whether, on the basis of the grounds enumerated in subrule 3.27(5), the applicant requests an opportunity to submit additional evidence.

3.28(3) The application shall be filed with the commissioner within 20 days after issuance of the final decision.

3.28(4) A copy of the application shall be timely mailed by the division to all parties of record not joining therein if the application does not contain a certificate of service demonstrating service on all parties.

3.28(5) Any application for a rehearing shall be deemed denied unless the commissioner grants the application within 20 days after its filing.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.29(17A) Stay of division action.

3.29(1) Petition requirements for stay of division action.

a. Any party to a contested case proceeding may petition the commissioner for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the division. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The commissioner may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the commissioner for a stay or other temporary remedy pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

3.29(2) In determining whether to grant a stay, the presiding officer or commissioner shall consider the factors listed in Iowa Code section 17A.19(5).

3.29(3) Any petition for stay of division action shall be deemed denied unless the commissioner grants the application within 20 days after its filing.

3.29(4) A stay may be vacated by the issuing authority upon application of the commissioner or any other party.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.30(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as is practicable.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.31(17A) Emergency adjudicative proceedings.

3.31(1) To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the division may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the division by emergency adjudicative order. Before issuing an emergency adjudicative order, the division shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the division is proceeding on the basis of reliable information;

b. Whether the specific circumstances that pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare;

e. Whether the specific action contemplated by the insurance division is necessary to avoid the immediate danger; and

f. Whether the proposed emergency adjudicative order is sufficiently limited in scope and narrowly tailored to protect the public health, safety or welfare.

3.31(2) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the division's decision to take immediate action.

a. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing the procedures specified in subrule 3.5(1).

b. If practical, the division shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

3.31(3) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the division shall make reasonable, immediate efforts to contact by telephone the persons who are required to comply with the order.

3.31(4) After issuance of an emergency adjudicative order, the division shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

3.31(5) A written emergency adjudicative order shall include notification of the date on which division proceedings are scheduled for completion. After an emergency adjudicative order is issued, continuance of further division proceedings to a later date will be granted only in compelling circumstances and upon written application.

3.31(6) This rule does not preclude issuance of summary cease and desist orders as authorized by Iowa Code sections 502.604, 502A.12, 523A.805, and 523D.13 and chapters 505, 507B, 507C, 508, and 515 and rule 191—3.32(502,505).

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.32(502,505,507B) Summary cease and desist orders. When a statute authorizes action to be taken without a prior hearing, the commissioner's order shall be sent to the last-known address of the party by certified mail, return receipt requested, unless the party is a licensee, in which case the order shall be sent by restricted certified mail. The order shall include a brief statement of findings of fact, conclusions of law and policy reasons for the decision; direct the person or insurer to cease and desist from engaging in the act or practice or to take other affirmative action as is necessary, in the judgment of the commissioner, to comply with the statute; and state that the party will be afforded a contested case proceeding and a hearing if a request is filed with the commissioner at least 30 days from the date that the order is issued, unless a different time is specified by statute. The commissioner shall issue a notice of hearing no later than 30 days from the date of receipt of a timely request for a contested case proceeding and hearing. If a statute requires a hearing to be held following issuance of a summary order, the date and time of that hearing shall be set forth in the order. Summary orders shall remain effective during the pendency of proceedings.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

191—3.33(17A,502,505) Settlement.

3.33(1) A party to a controversy that may culminate or has culminated in contested case proceedings may attempt settlement by complying with the procedures set forth in this subrule. No party shall be required to settle the controversy or contested case by submitting to settlement procedures.

3.33(2) Parties desiring settlement shall set forth in writing the various points of a proposed settlement, including findings of facts.

3.33(3) When signed by the parties and approved by the commissioner, a settlement shall represent final disposition of the matter.

3.33(4) When there is more than one party adverse to the division, a separate settlement between one party and the division is permissible.

3.33(5) A proposed settlement that is not accepted or signed by the parties and the commissioner shall not be admitted as evidence in the record of a contested case proceeding. Evidence of conduct

or statements made in settlement negotiations likewise are not admissible. This rule does not require exclusion when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negating a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution.

[**ARC 7731C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 4
WAIVER OF RULES AND DECLARATORY ORDERS

191—4.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules proposed or adopted by the division are subject to the provisions of Iowa Code chapter 17A and the provisions of this chapter.
[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.2(17A) Definitions. The definitions in Iowa Code section 17A.2 are incorporated into this chapter by this reference. In addition to those definitions and the definitions in rule 191—1.1(502,505), the following definitions apply:

"Commissioner" means the commissioner of insurance or the commissioner's designee. For the purposes of this chapter, "commissioner" includes both the commissioner of insurance and the administrator as defined in Iowa Code chapter 502.

"Waiver" means action by the division that suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.
[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.3(17A) Severability. If any provision of any rule adopted by the division, or if the application of any such rule to any person or circumstance, is for any reason held to be invalid, illegal or unenforceable by any court of law, the validity, legality and enforceability of the remainder of the rule and its application to other persons or circumstances shall not be affected or impaired thereby.
[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.4(17A) Public rulemaking docket. The division shall maintain on the division's website a current public rulemaking docket listing each pending rulemaking proceeding and relevant rulemaking information, including the information required by Iowa Code sections 17A.3(1)*"d"* and 17A.6A(2). If a rulemaking docket for all agencies is maintained on the Iowa legislature's website, the division may utilize the legislature's docket, in whole or in part, instead of creating a duplicative separate docket.
[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

DIVISION I
WAIVER OF RULES

191—4.5(17A) Waivers.

4.5(1) *Scope.* This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the division in situations when no other more specifically applicable law provides for waivers. This chapter shall not preclude the division from granting waivers in other contexts or on the basis of other standards if a statute or agency rule authorizes the division to do so and the division deems it appropriate to do so.

4.5(2) *Authority to grant waivers.* The division may grant a waiver from a rule only if the division has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The division may not waive the following categories of rules:

a. Rules setting requirements that are created or duties that are imposed by statute.

b. Rules that provide definitions or interpretations, set fees, clarify enforcement authority, deal with fraud or are the subject of prosecutorial discretion.

c. Rules that merely define the meaning of a statute or other provision of law or precedent if the commissioner does not possess delegated authority to bind the courts to any extent with the commissioner's definition.

4.5(3) *Criteria for order for waiver.* The division may in its sole discretion issue an order waiving in whole or in part the requirements of a rule if the division finds, based on clear and convincing evidence, all of the following:

a. Application of the rule would impose an undue hardship on the person for whom the waiver is requested;

b. Waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

c. Provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.6(17A) Petition for waiver. A petition for a waiver must be submitted in writing to the division as follows:

4.6(1) Applications. If the petition relates to an application or license, the petition must be made in accordance with the filing requirements for the application or license in question.

4.6(2) Contested cases. If the petition relates to a pending contested case, the petition must be filed in the contested case proceeding, using the caption of the contested case. The waiver petition shall be decided within the context of the contested case unless the presiding officer, other than the commissioner, determines that the petition should be referred directly to the commissioner.

4.6(3) Other. If the petition does not relate to an application or a pending contested case, the petition must be submitted to the division at the address in rule 191—1.4(502,505) or as instructed on the division's website.

4.6(4) Content of petition. A petition for waiver must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA INSURANCE COMMISSIONER

In the matter of: (Name of Person Requesting Waiver)	}	REQUEST FOR WAIVER OF RULE (Specify number of rule for which waiver is requested)

4.6(5) The petition shall provide the following information in separate numbered paragraphs:

1. The name, address and telephone number of the entity or person for whom a waiver is being requested, and the case number of any related contested case.
2. A description and citation of the specific rule from which a waiver is requested.
3. The specific waiver requested, including the precise scope and duration.
4. The relevant facts that the petitioner believes would justify a waiver under each of the criteria described in subrule 4.5(3). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes justify a waiver.
5. A history of any prior contacts between the division and the petitioner relating to the regulated activity, application or license affected by the proposed waiver, including a description of each affected license held by the petitioner, any notices of violation, contested case hearings, or investigative reports relating to the regulated activity or license within the prior five years and any waivers or waiver applications filed by the petitioner with the division within the prior five years.
6. Any information known to the petitioner regarding the division's treatment of similar cases.
7. The name, address and telephone number of any public agency or political subdivision that also regulates the activity in question or that might be affected by the granting of a waiver.
8. The name, address and telephone number of any entity or person who would be adversely affected by the granting of a waiver.
9. The name, address and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Signed releases of information authorizing persons with knowledge regarding the request to furnish the division with information relevant to the waiver.

4.6(6) Notice. The division must acknowledge a petition upon receipt and ensure that, within 30 days of the receipt of the petition, notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law. In addition, the division may give notice to other persons. To accomplish this notice provision, the division may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and to provide a written statement to the division attesting that notice has been provided.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.7(17A) Waiver hearing procedures and ruling.

4.7(1) *Procedures.* The provisions of Iowa Code sections 17A.10 through 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case and shall otherwise apply to agency proceedings for a waiver only when the division so provides by rule or order or is required to do so by statute.

4.7(2) *Additional information.* Prior to issuing an order granting or denying a waiver, the division may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the division may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the division.

4.7(3) *Division discretion.* The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the division, upon consideration of all relevant factors. Each petition for a waiver must be evaluated by the division based on the unique, individual circumstances set out in the petition.

4.7(4) *Ruling.* An order granting or denying a waiver must be in writing and must contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

4.7(5) *Burden of persuasion.* The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the division should exercise its discretion to grant a waiver from a division rule.

4.7(6) *Narrowly tailored exception.* A waiver, if granted, must provide the narrowest exception possible to the provisions of a rule.

4.7(7) *Administrative deadlines.* When the rule from which a waiver is sought establishes administrative deadlines, the division must balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

4.7(8) *Conditions.* The division may place any condition on a waiver that the division finds desirable to protect the public health, safety, and welfare.

4.7(9) *Time period of waiver.* A waiver must not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the division, a waiver may be renewed if the division finds that grounds for a waiver continue to exist.

4.7(10) *Time for ruling.* The division must grant or deny a petition for a waiver as soon as practicable but, in any event, must do so within 120 days of its receipt unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the division must grant or deny the petition no later than the time at which the final decision in that contested case is issued.

4.7(11) *When deemed denied.* Failure of the division to grant or deny a petition within the required time period shall be deemed a denial of that petition by the division. However, the division shall remain responsible for issuing an order denying a waiver.

4.7(12) *Service of order.* Within seven days of its issuance, any order issued under this chapter must be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

4.7(13) *Cancellation of a waiver.* A waiver issued by the division pursuant to this chapter may be withdrawn, canceled, modified or revoked if, after appropriate notice and hearing, the division issues an order finding any of the following:

a. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

b. The alternative means for ensuring that the public health, safety and welfare will be protected after issuance of the waiver order have been demonstrated to be insufficient; or

c. The subject of the waiver order has failed to comply with all conditions contained in the order; or

d. The waiver is contrary to the public health, safety and welfare in light of newly discovered evidence or changed circumstances.

4.7(14) *Violations.* Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

The rules in this division are intended to implement Iowa Code section 17A.9A and Executive Order Number 11 (September 14, 1999).

DIVISION II
DECLARATORY ORDERS

191—4.8(17A) Petition for declaratory order.

4.8(1) Any person or agency may file a petition with the division for a declaratory order as to the applicability to specified circumstances of a statute, rule or order within the primary jurisdiction of the division.

4.8(2) The petition must be submitted to the division at the address provided in rule 191—1.4(502,505) or as instructed on the division's website.

4.8(3) The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA INSURANCE COMMISSIONER

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	}	PETITION FOR DECLARATORY ORDER

4.8(4) The petition for declaratory order must provide the following information in separate numbered paragraphs:

1. The petitioner's name, address, and telephone number.
2. The citation to and the exact words, passages, sentences, or paragraphs of the statute, rule, or order that is the subject of the petition.
3. A clear and concise statement of all relevant facts upon which the declaratory order is requested.
4. The questions the petitioner wants answered, stated clearly and concisely.
5. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
6. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
7. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by any governmental entity.
8. Any request by the petitioner for a meeting provided for by rule 191—4.14(17A).

4.8(5) The petition for declaratory order must be dated and signed by the petitioner or the petitioner's representative.

4.8(6) If applicable, the petition must also include the name, mailing address, and telephone number of the petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

4.8(7) A petition is deemed filed when it is received by the division. The division must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the division an extra copy for this purpose.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.9(17A) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the division must give notice of the petition to all persons not served by the petitioner pursuant to rule 191—4.13(17A) to whom notice is required by any provision of law. The division may also give notice to any other persons deemed appropriate.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.10(17A) Intervention.

4.10(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order (after time for notice under rule 191—4.9(17A) and before 30-day time for division action under rule 191—4.15(17A)) shall be allowed to intervene in a proceeding for a declaratory order.

4.10(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the division.

4.10(3) A petition must be typewritten or legibly handwritten in ink and shall state in separately numbered paragraphs the following:

a. Facts supporting the intervenor's standing and qualifications for intervention.

b. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.

c. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.

d. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by any governmental entity.

e. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by or interested in the questions presented.

f. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

4.10(4) The petition must be dated and signed by the intervenor or the intervenor's representative and include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.11(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The division may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.12(17A) Inquiries. Inquiries concerning the status of a declaratory proceeding may be made to the division at the address disclosed in rule 191—1.4(502,505).

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.13(17A) Service and filing of petitions and other papers.

4.13(1) *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding and on all other persons

identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with its filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

4.13(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the division at the address disclosed in rule 191—1.4(502,505). All petitions, briefs, or other papers required to be served upon a party shall be filed simultaneously with the division.

4.13(3) *Method of service, time of filing, proof of mailing.* Method of service, time of filing, and proof of mailing shall be as provided by rule 191—3.12(17A).

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.14(17A) Consideration. Upon request by the petitioner, the division must schedule an informal meeting between the original petitioner, all intervenors, and the commissioner, or a member of the commissioner's staff, to discuss the questions raised.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.15(17A) Action on petition.

4.15(1) Within the time allowed by Iowa Code section 17A.9(5), after receiving a petition for a declaratory order, the division shall take action on the petition as required by Iowa Code section 17A.9(5).

4.15(2) The date of issuance of an order is as defined in rule 191—3.2(17A).

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.16(17A) Refusal to issue order.

4.16(1) The division shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for any of the following reasons:

a. The petition does not substantially comply with the required form.

b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by failure of the division to issue an order.

c. The division does not have jurisdiction over the questions presented in the petition.

d. The questions presented by the petition are also presented in a current rulemaking, contested case, or other agency or judicial proceeding that may definitively resolve them.

e. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.

f. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.

g. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a division decision already made.

i. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of the petitioner.

j. The petition requests the division to determine whether a statute is unconstitutional on its face.

4.16(2) A refusal by the division to issue a declaratory order must indicate the specific grounds for refusal and constitutes final agency action on the petition.

4.16(3) Refusal to issue a declaratory order pursuant to this rule does not preclude a petitioner from filing a new petition that seeks to eliminate the grounds for refusal to issue a ruling.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.17(17A) Contents of declaratory order—effective date.

4.17(1) In addition to the order itself, a declaratory order must contain the date of its issuance; the name of the petitioner and all intervenors; the specific statutes, rules, policies, decisions, or orders involved; the particular facts upon which it is based; and the reasons for its conclusion.

4.17(2) A declaratory order is effective on the date of issuance.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.18(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order must be mailed or emailed by the division promptly to the original petitioner and all intervenors.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

191—4.19(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the division, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the division. Issuance of a declaratory order constitutes final agency action on the petition.

[**ARC 7732C**, IAB 3/20/24, effective 4/24/24]

The rules in this division are intended to implement Iowa Code section 17A.9.

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UNFAIR TRADE PRACTICES

CHAPTER 14
LIFE INSURANCE ILLUSTRATIONS MODEL REGULATION

191—14.1(507B) Purpose. The purpose of this chapter is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. These rules provide illustration formats, prescribe standards to be followed when illustrations are used, and specify the disclosures that are required in connection with illustrations. The goals of these rules are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable. Insurers will, as far as possible, eliminate the use of footnotes and caveats and define terms used in the illustration in language that would be understood by a typical person within the segment of the public to which the illustration is directed.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.2(507B) Authority. These rules are issued based upon the authority granted the commissioner under Iowa Code section 507B.4.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.3(507B) Applicability and scope. These rules apply to all group and individual life insurance policies and certificates except:

1. Variable life insurance;
2. Individual and group annuity contracts;
3. Credit life insurance; or
4. Life insurance policies or certificates with initial face amounts of $10,000 or less.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.4(507B) Definitions. For the purposes of these rules:

"Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

"Contract premium" means the gross premium that is required to be paid under a fixed premium policy, including the premium for a rider for which benefits are shown in the illustration.

"Currently payable scale" means a scale of nonguaranteed elements in effect for a policy form as of the preparation date of the illustration or declared to become effective within the next 95 days.

"Disciplined current scale" means a scale of nonguaranteed elements constituting a limit on illustrations currently being illustrated by an insurer that is reasonably based on actual recent historical experience, as certified annually by an illustration actuary designated by the insurer. Further guidance in determining the disciplined current scale as contained in standards established by the Actuarial Standards Board may be relied upon if the standards:

1. Are consistent with all provisions of these rules;
2. Limit a disciplined current scale to reflect only actions that have already been taken or events that have already occurred;
3. Do not permit a disciplined current scale to include any projected trends of improvements in experience or any assumed improvements in experience beyond the illustration date; and
4. Do not permit assumed expenses to be less than minimum assumed expenses.

"Generic name" means a short title descriptive of the policy being illustrated such as "whole life," "term life" or "flexible premium adjustable life."

"Guaranteed elements" and *"nonguaranteed elements."*

1. "Guaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are guaranteed and determined at issue.
2. "Nonguaranteed elements" means the premiums, benefits, values, credits or charges under a policy of life insurance that are not guaranteed or not determined at issue.

"Illustrated scale" means a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyowner than the lesser of:

1. The disciplined current scale; or
2. The currently payable scale.

"Illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years and that is one of the three types defined below:

1. "Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and nonguaranteed elements.
2. "Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of this regulation, and that may be presented in a format differing from the basic illustration, but may only depict a scale of nonguaranteed elements that is permitted in a basic illustration.
3. "In-force illustration" means an illustration furnished at any time after the policy that it depicts has been in force for one year or more.

"Illustration actuary" means an actuary meeting the requirements of rule 191—14.11(507B) who certifies illustrations based on the standard of practice promulgated by the Actuarial Standards Board.

"Lapse-supported illustration" means an illustration of a policy form failing the test of self-supporting as defined in these rules, under a modified persistency rate assumption using persistency rates underlying the disciplined current scale for the first five years and 100 percent policy persistency thereafter.

"Minimum assumed expenses" means the minimum expenses that may be used in the calculation of the disciplined current scale for a policy form. The insurer may choose to designate each year the method of determining assumed expenses for all policy forms from the following:

1. Fully allocated expenses;
2. Marginal expenses; and
3. A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the National Association of Insurance Commissioners.

Marginal expenses may be used only if greater than a generally recognized expense table. If no generally recognized expense table is approved, fully allocated expenses must be used.

"Nonterm group life" means a group policy or individual policies of life insurance issued to members of an employer group or other permitted group where:

1. Every plan of coverage was selected by the employer or other group representative;
2. Some portion of the premium is paid by the group or through payroll deduction; and
3. Group underwriting or simplified underwriting is used.

"Policyowner" means the owner named in the policy or the certificate holder in the case of a group policy.

"Premium outlay" means the amount of premium assumed to be paid by the policyowner or other premium payer out of pocket.

"Self-supporting illustration" means an illustration of a policy form for which it can be demonstrated that, when using experience assumptions underlying the disciplined current scale, for all illustrated points in time on or after the fifteenth policy anniversary or the twentieth policy anniversary for second-or-later-to-die policies (or upon policy expiration if sooner), the accumulated value of all policy cash flows equals or exceeds the total policyowner value available. For this purpose, policyowner value will include cash surrender values and any other illustrated benefits amounts available at the policyowner's election.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.5(507B) Policies to be illustrated.

14.5(1) Each insurer marketing policies to which these rules are applicable shall notify the commissioner whether a policy form is to be marketed with or without an illustration. For policy forms filed after February 1, 1997, the illustration identification shall be made at the time of filing.

14.5(2) If the insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited.

14.5(3) If a policy form is identified by the insurer as one to be marketed with an illustration, a basic illustration prepared and delivered in accordance with these rules is required, except that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. The illustration given an applicant for a group life insurance policy or policies issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

14.5(4) Potential enrollees of nonterm group life subject to these rules shall be given a quotation with the enrollment materials. The quotation shall show potential policy values for sample ages and policy years on a guaranteed and nonguaranteed basis appropriate to the group and the coverage. This quotation shall not be considered an illustration for purposes of these rules, but all information provided shall be consistent with the illustrated scale. A basic illustration shall be provided at delivery of the certificate to enrollees for nonterm group life who enroll for pure death benefit protection. In addition, the insurer shall make a basic illustration available to any nonterm group life enrollee upon request.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.6(507B) General rules and prohibitions.

14.6(1) An illustration used in the sale of a life insurance policy shall satisfy the applicable requirements of these rules, be clearly labeled "life insurance illustration" and contain the following basic information:

a. Name of insurer;

b. Name and business address of producer or insurer's authorized representative, if any;

c. Name, age and sex of proposed insured, except where a composite illustration is permitted under these rules;

d. Underwriting or rating classification upon which the illustration is based;

e. Generic name of policy, the company product name, if different, and form number;

f. Initial death benefit; and

g. Dividend option election or application of nonguaranteed elements, if applicable.

14.6(2) When using an illustration in the sale of a life insurance policy, an insurer or its producers or other authorized representatives shall not:

a. Represent the policy as anything other than a life insurance policy;

b. Use or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

c. State or imply that the payment or amount of nonguaranteed elements is guaranteed;

d. Use an illustration that does not comply with the requirements of these rules;

e. Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

f. Provide an applicant with an incomplete illustration;

g. Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

h. Use the term "vanish" or "vanishing premium" or a similar term that implies the policy becomes paid up, to describe a plan for using nonguaranteed elements to pay a portion of future premiums;

i. Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or

j. Use an illustration that is not "self-supporting."

14.6(3) If an interest rate used to determine the illustrated nonguaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.7(507B) Standards for basic illustrations.

14.7(1) *Format.* A basic illustration shall conform with the following requirements:

a. The illustration shall be labeled with the date on which it was prepared.

b. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration (e.g., the fourth page of a seven-page illustration shall be labeled "page 4 of 7 pages").

c. The assumed dates of payment receipt and benefit payout within a policy year shall be clearly identified.

d. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the policy is assumed to have been in force.

e. The assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For policies that do not require a specific contract premium, the illustrated payments shall be identified as premium outlay.

f. Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium shall be shown and clearly labeled guaranteed.

g. If the illustration shows any nonguaranteed elements, they cannot be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements shall be clearly labeled nonguaranteed.

h. The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements (e.g., "see page 1 for guaranteed elements").

i. The account or accumulation value of a policy, if shown, shall be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.

j. The value available upon surrender shall be identified by the name this value is given in the policy being illustrated and shall be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy loan interest, as applicable.

k. Illustrations may show policy benefits and values in graphic or chart form in addition to the tabular form.

l. Any illustration of nonguaranteed elements shall be accompanied by a statement indicating that:

(1) The benefits and values are not guaranteed;

(2) The assumptions on which they are based are subject to change by the insurer; and

(3) Actual results may be more or less favorable.

m. If the illustration shows that the premium payer may have the option to allow policy charges to be paid using nonguaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on actual results, the premium payer may need to continue or resume premium outlays. Similar disclosure shall be made for premium outlay of lesser amounts or shorter durations than the contract premium. If a contract premium is due, the premium outlay display shall not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid up.

n. If the applicant plans to use dividends or policy values, guaranteed or nonguaranteed, to pay all or a portion of the contract premium or policy charges, or for any other purpose, the illustration may reflect those plans and the impact on future policy benefits and values.

14.7(2) *Narrative summary.* A basic illustration shall include the following:

a. A brief description of the policy being illustrated, including a statement that it is a life insurance policy;

b. A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration shall show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code;

c. A brief description of any policy features, riders or options, guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy;

d. Identification and a brief definition of column headings and key terms used in the illustration; and

e. A statement containing in substance the following: "This illustration assumes that the currently illustrated nonguaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown."

14.7(3) *Numeric summary.*

a. Following the narrative summary, a basic illustration shall include a numeric summary of the death benefits and values and the premium outlay and contract premium, as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values shall be based on the contract premium. This summary shall be shown for at least policy years 5, 10 and 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies, the summary shall show policy years 5, 10, 20 and 30.

(1) Policy guarantees;

(2) Insurer's illustrated scale;

(3) Insurer's illustrated scale used but with the nonguaranteed elements reduced as follows:

1. Dividends at 50 percent of the dividends contained in the illustrated scale used;

2. Nonguaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and

3. All nonguaranteed charges, including but not limited to term insurance charges, mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.

b. In addition, if coverage would cease prior to policy maturity or age 100, the year in which coverage ceases shall be identified for each of the three bases.

14.7(4) *Statements.* Statements substantially similar to the following shall be included on the same page as the numeric summary and signed by the applicant, or the policyowner in the case of an illustration provided at time of delivery, as required in these rules.

a. A statement to be signed and dated by the applicant or policyowner reading as follows: "I have received a copy of this illustration and understand that elements illustrated are subject to change and could be either higher or lower. The producer has told me they are not guaranteed."

b. A statement to be signed and dated by the insurance producer or other authorized representative of the insurer reading as follows: "I certify that this illustration has been presented to the applicant and that I have explained that any nonguaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."

14.7(5) *Tabular detail.*

a. A basic illustration shall include the following for at least each policy year from one to ten and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and except for term insurance beyond the twentieth year, for any year in which the premium outlay and contract premium, if applicable, is to change:

(1) The premium outlay and mode the applicant plans to pay and the contract premium, as applicable;

(2) The corresponding guaranteed death benefit, as provided in the policy; and

(3) The corresponding guaranteed value available upon surrender, as provided in the policy.

b. For a policy that provides for a contract premium, the guaranteed death benefit and value available upon surrender shall correspond to the contract premium.

c. Nonguaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any nonguaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any. If no guaranteed benefit or value is available at any duration for which a nonguaranteed benefit or value is shown, a zero shall be displayed in the guaranteed column.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.8(507B) Standards for supplemental illustrations.

14.8(1) A supplemental illustration may be provided so long as:

a. It is appended to, accompanied by or preceded by a basic illustration that complies with these rules;

b. The nonguaranteed elements shown are not more favorable to the policyowner than the corresponding elements based on the scale used in the basic illustration;

c. It contains the same statement required of a basic illustration that nonguaranteed elements are not guaranteed; and

d. For a policy that has a contract premium, the contract premium underlying the supplemental illustration is equal to the contract premium shown in the basic illustration. For policies that do not require a contract premium, the premium outlay underlying the supplemental illustration shall be equal to the premium outlay shown in the basic illustration.

14.8(2) The supplemental illustration shall include a notice referring to the basic illustration for guaranteed elements and other important information.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.9(507B) Delivery of illustration and record retention.

14.9(1) If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of that illustration, signed in accordance with these rules, shall be submitted to the insurer at the time of policy application. A copy shall also be provided to the applicant.

If the policy is issued other than as applied for, a revised basic illustration conforming to the policy as issued shall be sent with the policy. The revised illustration shall conform to the requirements of this rule, shall be labeled "Revised Illustration" and shall be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered. A copy shall be provided to the insurer and the policyowner.

14.9(2) If no illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy or if the policy is applied for other than as illustrated, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form the applicant shall acknowledge that no illustration conforming to the policy applied for was provided and shall further acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. This form shall be submitted to the insurer at the time of policy application.

If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed no later than the time the policy is delivered. A copy shall be provided to the insurer and the policyowner.

14.9(3) If the basic illustration or revised illustration is sent to the applicant or policyowner by mail from the insurer, it shall include instructions for the applicant or policyowner to sign the duplicate copy of the numeric summary page of the illustration for the policy issued and return the signed copy to the insurer. The insurer's obligation under this subrule shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the numeric summary page. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed numeric summary page.

14.9(4) A copy of the basic illustration and a revised basic illustration, if any, signed as applicable, along with any certification either that no illustration was used or that the policy was applied for other than as illustrated, shall be retained by the insurer until three years after the policy is no longer in force. A copy need not be retained if no policy is issued.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.10(507B) Annual report; notice to policyowners.

14.10(1) In the case of a policy designated as one for which illustrations will be used, the insurer shall provide each policyowner with an annual report on the status of the policy that shall contain at least the following information:

a. For universal life policies, the report shall include the following:

(1) The beginning and end date of the current report period;

(2) The policy value at the end of the previous report period and at the end of the current report period;

(3) The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (i.e., interest, mortality, expense and riders);

(4) The current death benefit at the end of the current report period on each life covered by the policy;

(5) The net cash surrender value of the policy as of the end of the current report period;

(6) The amount of outstanding loans, if any, as of the end of the current report period; and either

(7) For fixed premium policies: If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report; or

(8) For flexible premium policies: If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period unless further premium payments are made, a notice to this effect shall be included in the report.

b. For all other policies, where applicable:

(1) Current death benefit;

(2) Annual contract premium;

(3) Current cash surrender value;

(4) Current dividend;

(5) Application of current dividend; and

(6) Amount of outstanding loan.

c. Insurers writing life insurance policies that do not build nonforfeiture values shall only be required to provide an annual report with respect to these policies for those years when a change has been made to nonguaranteed policy elements by the insurer.

14.10(2) If the annual report does not include an in-force illustration, it shall contain the following notice displayed prominently: "IMPORTANT POLICYOWNER NOTICE: You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling [insurer's telephone number], writing to [insurer's name] at [insurer's address] or contacting your agent. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in-force illustration.

14.10(3) Upon the request of the policyowner, the insurer shall furnish an in-force illustration of current and future benefits and values based on the insurer's present illustrated scale. This illustration shall comply with the requirements of subrules 14.6(1), 14.6(2), 14.7(1) and 14.7(5). No signature or other acknowledgment of receipt of this illustration shall be required.

14.10(4) If an adverse change in nonguaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report shall contain a notice of that fact and the nature of the change prominently displayed.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.11(507B) Annual certifications.

14.11(1) The board of directors of each insurer shall appoint one or more illustration actuaries.

14.11(2) The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations promulgated by the Actuarial Standards Board, and that the illustrated scales used in insurer-authorized illustrations meet the requirements of these rules**.**

14.11(3) The illustration actuary shall:

a. Be a member in good standing of the American Academy of Actuaries;

b. Be familiar with the standard of practice regarding life insurance policy illustrations;

c. Not have been found by the commissioner, following appropriate notice and hearing, to have:

(1) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of dealings as an illustration actuary;

(2) Been found guilty of fraudulent or dishonest practices;

(3) Demonstrated incompetence, lack of cooperation, or untrustworthiness to act as an illustration actuary; or

(4) Resigned or been removed as an illustration actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of a failure to adhere to generally acceptable actuarial standards;

d. Not fail to notify the commissioner of any action taken by a commissioner of another state similar to that under paragraph 14.11(3)*"c"*;

e. Disclose in the annual certification whether, since the last certification, a currently payable scale applicable for business issued within the previous five years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar in-force policies, this must be disclosed in the annual certification. If nonguaranteed elements illustrated for both new and in-force policies are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this must be disclosed in the annual certification; and

f. Disclose in the annual certification the method used to allocate overhead expenses for all illustrations:

(1) Fully allocated expenses;

(2) Marginal expenses; or

(3) A generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the National Association of Insurance Commissioners.

14.11(4) The illustration actuary shall file a certification with the board and with the commissioner:

a. Annually for all policy forms for which illustrations are used; and

b. Before a new policy form is illustrated.

If an error in a previous certification is discovered, the illustration actuary shall notify the board of directors of the insurer and the commissioner promptly.

14.11(5) If an illustration actuary is unable to certify the scale for any policy form illustration the insurer intends to use, the actuary shall notify the board of directors of the insurer and the commissioner promptly of the actuary's inability to certify.

14.11(6) A responsible officer of the insurer, other than the illustration actuary, shall certify annually:

a. That the illustration formats meet the requirements of these rules and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary; and

b. That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in paragraph 14.11(3)*"f."*

14.11(7) The annual certifications shall be provided to the commissioner each year by a date determined by the insurer.

14.11(8) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the commissioner of that fact promptly and disclose the reason for the change.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.12(507B) Penalties. In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of these rules shall be found to have committed a violation of Iowa Code section 507B.4.

[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.13(507B) Severability. If any provision of these rules or their application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rules and their application to other persons or circumstances shall not be affected.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

191—14.14(507B) Effective date. These rules are effective as of April 24, 2024, and apply to policies sold on or after February 1, 1997.
[**ARC 7733C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapter 507B.

[Filed 10/4/96, Notice 7/3/96—published 10/23/96, effective 2/1/97]
[Filed ARC 7733C (Notice ARC 7348C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

CHAPTER 15
UNFAIR TRADE PRACTICES
[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
SALES PRACTICES

191—15.1(507B) Purpose. This chapter is intended to establish certain minimum standards and guidelines of conduct by identifying unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as prohibited by Iowa Code chapter 507B.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.2(507B) Definitions.

"Advertisement" for the purpose of these rules means material designed to create public interest in insurance or an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

1. Printed and published material, audio and visual material, and descriptive literature of an insurer or producer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, computer online networks and similar displays and descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public.

2. However, for the purpose of these rules "advertisement" shall not include: communications or materials used within an insurer's own organization and not intended for dissemination to the public; communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy; and a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

"Aftermarket crash parts" means replacement parts as defined in Iowa Code section 537B.4.

"Certificate" means a statement of the coverage and provisions of a policy of group accident and sickness insurance that has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

"Duplicate Medicare supplement insurance" means the sale or the attempt to knowingly sell to an individual a policy of insurance designed to supplement Medicare benefits as provided in Title XVIII, Health Insurance for the Aged and Disabled, of the Social Security Amendments of 1965 as then constituted or later amended, when the individual is already insured under such a policy.

"Duplication" means policies of the same coverage type according to minimum standards classifications outlined in rule 191—36.6(514D) that overlap to the extent that a reasonable individual would not consider the ownership of the policies to be beneficial.

"Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

"Illustrated scale" means a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale as defined in rule 191—14.4(507B).

"Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the business of insurance.

"Invitation to contract" means an advertisement for accident and sickness insurance that is neither an invitation to inquire nor an institutional advertisement.

"Invitation to inquire" means an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss

for which benefits are payable. An invitation to inquire must not refer to cost but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.

"Limitation" for the purpose of these rules means any provision that restricts coverage under the policy other than an exception or a reduction.

"Limited benefit health coverage" means the same as defined in 191—subrule 36.6(10).

"Person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers and adjusters. "Person" also means any corporation operating under the provisions of Iowa Code chapter 514 and any benevolent association as defined and operated under Iowa Code chapter 512A. For purposes of this chapter, corporations operating under the provisions of Iowa Code chapters 514 and 512A shall be deemed to be engaged in the business of insurance.

"Policy" includes any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement that provides for insurance benefits.

"Preneed funeral contract or prearrangement" means an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

"Producer" means a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located or to be performed in this state.

"Prominently" or *"conspicuously"* means that the information to be disclosed will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

"Reduction" for the purpose of these rules means any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

"Twisting" means any action by a producer or insurer to induce or attempt to induce any individual to lapse, forfeit, surrender, terminate, retain, assign, borrow, or convert a policy or an annuity in order that such individual procure another policy or annuity, when such action would operate to the overall detriment of the interests of the individual.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.3(507B) Advertising.

15.3(1) *Form and content of advertisements.* The format and content of an advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to misrepresent or deceive. Whether an advertisement has a capacity or tendency to misrepresent or deceive shall be determined by the overall impression that the advertisement may be reasonably expected to create upon an individual in the segment of the public to which it is primarily directed and who has average education, intelligence and familiarity with insurance terminology for products in that market.

Information regarding exceptions, limitations, reductions and other restrictions required to be disclosed by this rule shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

15.3(2) *Prohibited terms and disclosure requirements for health insurance.*

a. No advertisement shall contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases in a manner that exaggerates any benefits beyond the terms of the policy.

b. No advertisement shall contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free," "extra cash" and substantially similar

phrases that have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable an individual to make a profit from being hospitalized.

d. No advertisement shall use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

e. An advertisement that refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

f. An advertisement may contain a brief description of coverage in an invitation to inquire so long as it is limited to a brief description of the loss for which benefits are payable. The brief description may not refer to the cost of the policy.

g. An advertisement for a policy that contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss shall prominently disclose the existence of such periods.

h. An invitation to inquire shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

15.3(3) *Prohibited terms in life insurance and annuity policies.* No advertisement for a life insurance or annuity policy shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "retirement plan," or other similar term that has the capacity or tendency to mislead an insured or prospective insured to believe that the insurer is offering something other than an insurance policy or some benefit not available to other individuals of the same class and equal expectation of life. An advertisement shall not state that there are "no more premiums" or that premiums will "vanish" or "disappear" or use similar terms when such statement is not based on the guaranteed rates.

15.3(4) *Exclusions, limitations, exceptions and reductions.* Words and phrases used in an advertisement to describe policy exclusions, limitations, exceptions and reductions shall clearly, prominently and accurately indicate the negative or limited nature of the exclusions, limitations, exceptions and reductions.

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or other policies providing benefits that are limited in nature shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS POLICY PROVIDES LIMITED BENEFITS," or "THIS IS A CANCER-ONLY POLICY."

15.3(5) *Use of statistics.* An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

15.3(6) *Introductory, initial or special offers.*

a. An advertisement shall not directly or by implication represent that a policy is an introductory, initial or special offer, or that a person will receive advantages not available at a later date, or that the offer is available only to a specified group of persons, unless such is the fact.

b. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in each portion of the advertisement where the initial reduced premium appears. This paragraph shall not apply to annual renewable term policies.

15.3(7) *Testimonials or endorsements by third parties.*

a. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to these rules.

b. If the person making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements constitutes compensation and requires disclosure.

c. An advertisement that states or implies that an insurer or an insurance product has been approved or endorsed by any person or other organizations must also disclose any proprietary or other relationship between the parties.

15.3(8) *Disparaging and incomplete comparisons and statements.* An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage other insurers, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of an insurer in the insurance business.

15.3(9) *Identity of insurer.*

a. The name of the actual insurer shall be clearly identified in all advertisements for a particular policy. An advertisement shall not use a trade name, insurance group designation, name of a parent company, name of a particular company division, service mark, slogan, symbol or other device that would have the capacity and tendency to misrepresent the true identity of an insurer.

b. No advertisement shall use any combination of words, symbols, or physical materials that by its content, phraseology, shape, color or other characteristics is so similar to combinations of words, symbols, or physical materials used by a municipal, state or federal agency that it would lead a reasonable individual to believe that the advertisement is approved, endorsed or accredited by an agency of the municipal, state, or federal government.

15.3(10) *Disclosure requirements for life insurance and annuities.*

a. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

b. An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

c. Dividends.

(1) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends for an annuity are illustrated, the illustration must be based on the insurer's illustrated scale and must contain a statement that the illustration is not to be construed as a guarantee or estimate of dividends to be paid in the future.

(2) An advertisement shall not state or imply that the illustrated scale under a participating policy or pure endowments will be or can be sufficient at any future time to ensure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

d. An advertisement of a deferred annuity shall not state the net premium accumulation interest rate unless it discloses in close proximity thereto and with equal prominence the actual relationship between the gross and net premiums.

e. An advertisement that states the projected values of a policy must use the guaranteed interest rates in determining such projected values and, in addition, may show other projected values based on interest rates that comply with the illustrated scale. Any statements containing or based upon an interest

rate higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable statements containing or based upon the guaranteed accumulation interest rates. If the policy does not contain a provision for a guaranteed interest rate, any advertisement showing projected values must clearly state that the rates are not guaranteed. This subrule does not apply to an illustration or supplemental illustration subject to the provisions of the Life Insurance Illustrations Model Regulation, 191—Chapter 14.

f. An advertisement or presentation that does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such advertisement may be used for the purpose of demonstrating the cash flow pattern of a policy if such advertisement is accompanied by a statement disclosing that the advertisement does not recognize that, because of interest, a dollar in the future may not have the same value as a dollar at the time of the presentation.

g. An advertisement of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are also shown separately in close proximity thereto.

h. A statement regarding the use of life insurance cost indexes shall include an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

i. A life insurance cost index that reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the insurer's illustrated scale and is not guaranteed.

15.3(11) *Special offers.* Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had the recipient's eligibility for the insurance individually determined in advance when the advertisement is directed to all individuals in a group or to all individuals whose names appear on a mailing list.

15.3(12) *Disclosure requirement.* In an advertisement that is an invitation to contract for an accident and sickness insurance policy that is guaranteed renewable, cancelable or renewable at the option of the company, the advertisement shall disclose that the insurer has the right to increase premium rates if the policy so provides.

15.3(13) *Group or quasi-group implications.*

a. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and, as members, enjoy special rates or underwriting privileges, unless that is the fact.

b. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements that state or imply that the class membership entitles the member to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

c. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

d. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct application required need not be on a separate document or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, the use of terms such as "enroll" or "join" to imply group or blanket insurance coverage is prohibited when that is not the fact.

e. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

15.3(14) *Compliance with Medicare supplement advertising rules.* Insurers and producers shall comply with the Medicare supplement advertising rules set forth in 191—Chapter 37.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.4(507B) Life insurance cost and benefit disclosure requirements.

15.4(1) The definition of terms applicable to this rule and its appendices will be found in Appendix I.

15.4(2) Except as hereafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any insurer issuing life insurance contracts including fraternal benefit societies.

Unless otherwise specifically included, this rule shall not apply to:

a. Annuities.

b. Credit life insurance.

c. Group life insurance, except for disclosures relating to preneed funeral contracts or prearrangements as provided herein. These disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy.

d. Life insurance policies issued in connection with pension and welfare plans as defined by and that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

e. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

15.4(3) Prior to or at delivery of a life insurance policy, an insurer or producer shall provide the prospective purchaser the following:

a. A life insurance buyer's guide in the current form prescribed by the National Association of Insurance Commissioners or language approved by the commissioner of insurance, and

b. A policy summary as defined in Appendix I.

15.4(4) A policy summary is not required to include information available in the policy form or illustration. If an illustration subject to the provisions of 191—Chapter 14, Life Insurance Illustrations Model Regulation, is used in the sale of a policy, delivery of a policy summary is not required. A policy summary may not include any element that is not guaranteed.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.5(507B) Health insurance sales to individuals 65 years of age or older. The sale of duplicate Medicare supplement insurance is prohibited.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.6 Reserved.

191—15.7(507B) Twisting prohibited. No insurer or producer shall engage in the act of twisting.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.8(507B) Producer responsibilities.

15.8(1) *Required disclosures.* A producer shall inform the prospective purchaser, prior to commencing an insurance sales presentation, that the producer is acting as an insurance producer and inform the prospective purchaser of the producer's full name and the full name of the insurance company that the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify the insurer's full name to a prospective purchaser.

15.8(2) *Improper sales tactics.*

a. Producers and insurers shall not employ any method of marketing or tactic that uses undue pressure, force, fright, threat, whether explicit or implied, to solicit the purchase of insurance.

b. A producer shall not:

(1) Execute a transaction for an insurance customer without authorization by the customer to do so; or

(2) Commit any act that shows that the producer has exerted undue influence over a person.

c. Producers and insurers shall not, without good cause:

(1) Fail or refuse to furnish any individual, upon reasonable request, information to which that individual is entitled, or to respond to a formal written request or complaint from any individual.

(2) Sell an insurance policy or rider to an individual that is a duplication of a policy or rider that the individual owns or for which the individual has applied at the time of the sale.

15.8(3) *Prohibited designations and fees.*

a. When an insurance producer is engaged only in the sale of insurance policies or annuities, the insurance producer shall not hold the producer out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist solely engaged in the business of financial planning or giving advice relating to investments, insurance, real estate, tax matters or trust and estate matters. This provision does not preclude insurance producers who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance.

b. An insurance producer shall not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement required by paragraph 15.8(3)*"c"* or to the solicitation of the sale of a product or service that the producer is also an insurance producer and that a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including the disclosure in any disclosure required by federal or state securities law.

c. An insurance producer shall not charge fees other than commissions unless such fees are based upon a written agreement signed by the client in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the client at the time the agreement is signed by the client. The agreement must specifically state:

(1) The service for which the fee is to be charged;

(2) The amount of the fee to be charged or how it will be determined or calculated; and

(3) That the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

d. Producers shall not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. This prohibition shall not apply to assigned risk policies and commercial property and casualty policies. Any additional fee that a producer intends to charge for assigned risk policies and commercial property and casualty policies must be fully disclosed to the insured.

e. Producers shall comply with rule 191—10.19(522B) in using senior-specific certifications and professional designations in the sale of life insurance and annuities.

15.8(4) *Suitability.* A producer shall not recommend to any person the purchase, sale or exchange of any life insurance policy, or any rider, endorsement or amendment thereto, without reasonable grounds to believe that the transaction or recommendation is not unsuitable for the person based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information known by the producer. For purposes of this subrule, when a producer recommends a group life insurance policy, "person" shall refer to the intended group policyowner.

15.8(5) *Prohibited acts.*

a. For purposes of this subrule:

"Gift" means a rendering of anything of value in return for which legal consideration of equal or greater value is not given and received.

"Immediate family" shall include parent, mother-in-law, father-in-law, spouse, former spouse, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, child and stepchild. In

addition, "immediate family" shall include any other person who is supported, directly or indirectly, to a material extent by a producer.

"Loan" means an agreement to advance property, including but not limited to money, in return for the promise that payment will be made for use of the property.

b. A producer shall not:

(1) Solicit or accept, directly or indirectly, at any time, a personal loan from an insurance customer that in the aggregate exceeds $250, unless the customer is:

1. A bank, savings and loan, credit union or other recognized lending entity; or
2. A member of the producer's immediate family.

(2) Solicit or accept, directly or indirectly, at any time, a gift to the producer or to a member of the producer's immediate family from an insurance customer that in the aggregate exceeds $250, unless the customer is a member of the producer's immediate family. A gift to a member of the producer's immediate family shall be included in calculating the aggregate amount. A gift received by a member of the producer's immediate family from a customer that is not a member of the producer's immediate family in excess of the aggregate amount shall be deemed a violation of this subrule by the producer.

(3) Solicit or accept being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity of a customer, unless the customer is a member of the producer's immediate family.

(4) Evade or otherwise violate the spirit of this subrule by terminating a producer relationship with an insurance customer for the purpose of soliciting or accepting a loan or a gift, or for the purpose of being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity that the producer otherwise would have been prohibited from soliciting or accepting by this subrule. A producer will not be in violation of this subrule if the producer has made a bona fide termination of the producer relationship with the insurance customer and has conducted no insurance or other business with the insurance customer for a period of three years.

c. Transactions that involve nominal interim ownership immediately precedent to transfer of ownership into a trust are exempt from this subrule.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.9(507B) Right to return a life insurance policy or annuity (free look). The owner of an individual policy has the right, within ten days after receipt of a life insurance policy or annuity, to a free-look period. During this period, the policyowner may return the life insurance policy or annuity to the insurer at its home office, branch office, or to the producer through whom it was purchased. If so returned, the premium paid will be promptly refunded, the policy or annuity voided and the parties returned to the same position as if a policy or annuity had not been issued. If the transaction involved a replacement, the length of the free-look period will be determined according to 191—Chapter 16.

If the transaction involved a variable product, the amount to be refunded shall be determined according to the policy language. The calculations must comply with the relevant rule in either 191—Chapter 16, Replacement of Life Insurance and Annuities, or 191—Chapter 33, Variable Life Insurance Model Regulation.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.10(507B) Uninsured/underinsured automobile coverage—notice required.

15.10(1) *Contents of notice.* Automobile insurance policies delivered in this state shall include a notice that contains and is limited to the following language:

NOTICE REGARDING UNINSURED/UNDERINSURED COVERAGE

Uninsured/underinsured coverage does not cover damage done to your vehicle. It provides benefits only for bodily injury caused by an uninsured or underinsured motorist. If you wish to be insured for damage done to your vehicle, you must have collision coverage. Please check your policy to make sure you have the coverage desired.

15.10(2) *Form of notice.* Notice may be provided on a separate form or may be stamped on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application but shall in no case be provided later than the time of

delivery of the new policy. Insurers may inform applicants that the notice in this rule is required by the insurance division.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.11(507B) Unfair discrimination.

15.11(1) *Sex discrimination.*

a. A contract shall not be denied to an individual based solely on that individual's sex or marital status. No benefits, terms, conditions or type of coverage shall be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured except to the extent permitted under the Iowa Code or Iowa Administrative Code. An insurer may consider marital status for the purpose of defining individuals eligible for dependents' benefits. This subrule does not apply to group life insurance policies or group annuity contracts issued in connection with pension and welfare plans that are subject to the federal ERISA.

b. Specific examples of practices prohibited by this subrule include, but are not limited to, the following:

(1) Denying coverage to individuals of one sex employed at home, employed part-time or employed by relatives when coverage is offered to individuals of the opposite sex similarly employed.

(2) Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.

(3) Denying a policy under which maternity coverage is available to an unmarried female when that same policy is available to a married female.

(4) Denying, under group contracts, dependent coverage to spouses of employees of one sex, when dependent coverage is available to spouses of employees of the opposite sex.

(5) Denying disability income coverage to employed members of one sex when coverage is offered to members of the opposite sex similarly employed.

(6) Treating complications of pregnancy differently from any other illness or sickness under the contract.

(7) Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one sex.

(8) Offering lower maximum monthly benefits to members of one sex than to members of the opposite sex who are in the same underwriting and occupational classification under a disability income contract.

(9) Offering more restrictive benefit periods and more restrictive definitions of disability to members of one sex than to members of the opposite sex in the same underwriting and occupational classifications under a disability income contract.

(10) Establishing different contract conditions based on gender that limit the benefit options a policyholder may exercise.

(11) Limiting the amount of coverage due to an insured's or prospective insured's marital status unless such limitation applies only to coverage for dependents and is uniformly applied to males and females.

c. When rates are differentiated on the basis of sex, an insurer must, upon the request of the commissioner of insurance, justify the rate differential in writing to the satisfaction of the commissioner. All rates shall be based on sound actuarial principles or a valid classification system and actual experience statistics, if available.

d. This subrule shall not affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this subrule is applicable to the insurance benefits available to its members.

15.11(2) *Physical or mental impairment.* No contract, benefits, terms, conditions or type of coverage shall be denied, restricted, modified, excluded or reduced solely on the basis of physical or mental impairment of the insured or prospective insured except where based on sound actuarial principles or related to actual or reasonably anticipated experience. For purposes of this subrule, both blindness and partial blindness shall be considered a physical impairment.

15.11(3) *Income discrimination.* An insurer shall not refuse to issue, limit the amount or apply different rates to individuals of the same class in the sale of individual life insurance based solely upon the prospective insured's legal source or level of income, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The portion of this subrule pertaining to level of income does not:

a. Apply to the sale of disability income insurance of any kind or of any insurance designed to protect against economic loss due to a disruption in the regular flow of an individual's earned income;

b. Prohibit the sale of any insurance or annuity that is made available only to employees;

c. Prohibit basing the amount of insurance sold to an employee on a multiple or a percentage of the employee's salary or prohibit limiting availability to employees who have achieved a certain employment status as defined by the employer;

d. Prohibit insurers from providing life or health insurance as an incidental benefit through a qualified pension plan;

e. Prohibit insurers from applying suitability standards that include income as a factor in the sale of any life insurance or annuity products;

f. Prohibit insurers from establishing maximum or minimum amounts of insurance that will be issued to individuals so long as this is pursuant to a preexisting specialized marketing strategy that the insurer can demonstrate is related to the financial capacity of the insurer to write business or to bona fide transaction costs.

15.11(4) *Domestic abuse.* A contract shall not be denied to an individual based solely on the fact that such individual has been or is believed to have been a victim of domestic abuse as defined in Iowa Code section 236.2.

15.11(5) *Genetic information.* Any action by an insurer that is not in compliance with Title I of the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881) shall be considered an unfair trade practice and shall be subject to the penalties of Iowa Code chapter 507B and of these rules.

15.11(6) *Discrimination relating to children under the age of 19.* It is an unfair trade practice to:

a. Encourage individuals or groups to refrain from filing an application with an insurer for coverage for a child under the age of 19 because of the child's health status, claims experience, industry, occupation, or geographic location;

b. Encourage or direct children under the age of 19 to seek coverage from another insurer because of the child's health status, claims experience, industry, occupation, or geographic location; and

c. Encourage an employer to exclude an employee from coverage.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.12(507B) Testing restrictions of insurance applications for the human immunodeficiency virus.

15.12(1) *Written release.* No insurer shall obtain a test of any individual in connection with an application for insurance for the presence of an antibody to the human immunodeficiency virus unless the individual to be tested provides a written release on a form that contains the following information:

a. A statement of the purpose, content, use, and meaning of the test.

b. A statement regarding disclosure of the test results including information explaining the effect of releasing the information to an insurer.

c. A statement of the purpose for which test results may be used.

15.12(2) *Form.* A preapproved form is provided in Appendix II. An insurer wishing to utilize a form that deviates from the language in the appendix to these rules shall submit the form to the insurance division for approval. Any form containing, but not limited to, the language in the appendix shall be deemed approved.

15.12(3) *Test results.* A person engaged in the business of insurance who receives results of a positive human immunodeficiency virus (HIV) test in connection with an application for insurance shall report those results to a physician or alternative testing site of the applicant's or policyholder's choice

or, if the applicant or policyholder does not choose a physician or alternative testing site to receive the results, to the Iowa department of health and human services.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.13(507B) Records maintenance.

15.13(1) *Complaint and business records.*

a. An insurer shall maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner.

b. An insurer shall maintain a complete record of all the complaints received since the date of its last examination by the insurer's state of domicile or port-of-entry state. This record shall indicate the total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix III sets forth the minimum information required to be contained in the complaint record.

15.13(2) *Insurer's control over advertisements.* Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements that explain a particular policy. All such advertisements, whether written, created, designed or presented by the insurer or its appointed producer, shall be the responsibility of the insurer whose particular policies are so advertised. As part of this requirement, each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance division. All such advertisements shall be maintained for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

15.13(3) *Education and training materials.* Every insurer shall establish and maintain a system of control over the content and form of all material used by the insurer or any of its employees for the recruitment, training, and education of producers in the sale of insurance. Upon request, copies of these materials shall be made available to the commissioner.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.14(505,507B) Enforcement section—cease and desist and penalty orders.

15.14(1) If, after hearing, the commissioner determines that a person has engaged in an unfair trade practice in violation of these rules, an unfair method of competition, or an unfair or deceptive act or practice in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring the person to cease and desist from engaging in such method of competition, act or practice. The commissioner also may order one or more of the following:

a. Payment of a civil penalty of not more than $1,000 for each act or violation, but not to exceed an aggregate penalty of $10,000, unless the person knew or reasonably should have known that the actions were in violation of these rules or of Iowa Code chapter 507B, in which case the penalty shall be not more than $5,000 for each act or violation, but not to exceed an aggregate penalty of $50,000 in any one six-month period. If the commissioner finds that a violation of these rules or of Iowa Code chapter 507B was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer;

b. Suspension or revocation of an insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of these rules or of Iowa Code chapter 507B;

c. Payment of interest at the rate of 10 percent per annum if the commissioner finds that the insurer failed to pay interest as required under Iowa Code section 507B.4(3)*"p"*;

d. Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;

e. Payment of the costs of the investigation and administrative expenses related to any act or violation. The commissioner may retain funds collected pursuant to any settlement, enforcement action,

or other legal action authorized under federal or state law for the purpose of reimbursing costs and expenses of the division.

15.14(2) Any person who violates a cease and desist order of the commissioner while such order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or both of the following:

a. A civil penalty of not more than $10,000 for each and every act or violation.

b. Suspension or revocation of such person's license.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.15 to **15.30** Reserved.

DIVISION II
CLAIMS

191—15.31(507B) General claims settlement guidelines. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.32(507B) Prompt payment of certain health claims. Effective July 1, 2002, the following provisions apply:

15.32(1) *Definitions and scope.*

a. For purposes of this rule, the following definitions apply:

"Circumstance requiring special treatment" means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or

2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or

3. Similar unique or special circumstances that would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means the same as defined in Iowa Code section 507B.4A.

"Coordination of benefits for third-party liability" means a claim for benefits by a covered individual who has coverage under more than one health benefit plan.

"Insurer" means insurer as defined in Iowa Code section 507B.4.

"Properly completed billing instrument" means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual; or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

b. Scope. This subrule applies to claims submitted to an insurer as defined above on or after July 1, 2002, and is limited to policies issued, issued for delivery, or renewed in this state.

15.32(2) *Insurer duty to promptly pay claims and pay interest.*

a. Insurers subject to this subrule shall either accept and pay or deny a clean claim for health care benefits under a benefit certificate or policy issued by the insurer within 30 days after the insurer's receipt of such claim. A clean claim is considered to be paid on the date upon which a check, draft, or other valid negotiable instrument is written. Insurers shall implement procedures to ensure that these payments are promptly delivered.

b. Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer's receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer's receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

c. Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

d. Effective January 1, 2003, when a claim involves coordination of benefits, an insurer is required to comply with the requirements of this subrule when that insurer's liability has been determined.

15.32(3) *Certain insurance products exempt.* Claims paid under the following insurance products are exempt from the provisions of this subrule: liability insurance, workers' compensation or similar insurance, automobile or homeowners insurance, medical payment insurance or disability income insurance.

This rule is intended to implement Iowa Code sections 507B.4A, 514G.102 and 514G.111.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.33(507B) Audit procedures for medical claims.

15.33(1) *Prohibitions.* This rule applies to all claims paid on or after January 1, 2002:

a. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

b. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than $25.

15.33(2) *Standards.*

a. In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

b. In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

15.33(3) *Contents of audit request.* All correspondence regarding the audit of a claim must include the following information:

a. The name, address, telephone number and contact person of the insurer conducting the audit,

b. The name of the entity performing the audit if not the insurer,

c. The purpose of the audit, and

d. If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4(3)*"j"*(15).

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.34 to **15.40** Reserved.

191—15.41(507B) Claims settlement guidelines for property and casualty insurance. For purposes of this rule, "insurer" means property and casualty insurers.

15.41(1) An insurer shall fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

15.41(2) Within 30 days after receipt by the insurer of properly executed proofs of loss, the first-party property claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing, and the claim file of the insurer shall contain documentation of the denial.

When there is a reasonable basis supported by specific information available for review by the commissioner that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(3) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, the insurer shall so notify the first-party claimant within 30 days after receipt of the proof of loss and give the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

When there is a reasonable basis supported by specific information available for review by the commissioner for suspecting that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(4) Insurers shall not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

15.41(5) No insurer shall make statements indicating that the rights of a third-party claimant may be impaired if a form or release, other than a release to obtain medical records, is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

15.41(6) The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within 30 days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments that are not in dispute under one of the coverages and where the payee is known should be tendered within 30 days if such payment would terminate the insurer's known liability under that coverage.

15.41(7) No producer shall conceal from a first-party claimant benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

15.41(8) A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions to exhibit or cooperate in the claim investigation.

15.41(9) No insurer shall deny a claim based upon the failure of a first-party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition. An insurer may deny a claim if the claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

15.41(10) No insurer shall indicate to a first-party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract.

15.41(11) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.42(507B) Acknowledgment of communications by property and casualty insurers. For purposes of this rule, "insurer" means property and casualty insurers.

15.42(1) Upon receiving notification of a claim, an insurer shall, within 15 days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgment is made

by means other than in writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated.

15.42(2) Upon receipt of any inquiry from the Iowa insurance division regarding a claim, an insurer shall, within 21 days of receipt of such inquiry, furnish the division with an adequate response to the inquiry, in duplicate.

15.42(3) The insurer shall reply within 15 days to all pertinent communications from a claimant that reasonably suggest that a response is expected.

15.42(4) Upon receiving notification of claim, an insurer shall promptly provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subrule within 15 days of notification of a claim shall constitute compliance with subrule 15.42(1).

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.43(507B) Standards for settlement of automobile insurance claims.

15.43(1) Loss calculation and deviation guidelines.

a. Loss calculation. When the insurance policy provides for the adjustment and settlement of first-party automobile total losses on the basis of actual cash value or replacement with another automobile of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. All applicable taxes, license fees and other fees incident to the transfer of evidence of ownership of the automobile shall be paid by the insurer, at no cost to the insured, other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last 90 days to consumers in the local market area; or

2. The cost of two or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last 90 days to consumers when comparable automobiles are not available in the local market area; or

3. One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles is not available; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

- The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area.
- The source's database shall produce values for at least 85 percent of all makes and models for the last 15 model years taking into account the values of all major options for such vehicles.
- The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to ensure statistical validity.

(3) If the insurer is notified within 35 days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for such market value, the insured shall have a right of recourse. The insurer shall reopen its claim file and the following procedure(s) shall apply:

1. The insurer may locate a comparable vehicle by the same manufacturer, same or newer year, similar body style and similar options and price range for the insured for the market value determined by the insurer at the time of settlement. Any such vehicle must be available through a licensed dealer; or

2. The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality that the insured has located, or negotiate and effect the purchase of this vehicle for the insured; or

3. The insurer may elect to offer a replacement in accordance with the provisions set forth in subrule 15.43(1); or

4. The insurer may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The insurer is not required to take action under this subrule if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same or newer year, similar body style and similar options in as good or better condition as the total-loss vehicle that could have been purchased for the market value determined by the insurer before applicable deductions. The documentation shall include the vehicle identification number.

b. Deviation. When a first-party automobile total loss is settled on a basis that deviates from the methods described in paragraph 15.43(1)*"a,"* the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first-party claimant.

15.43(2) Where liability and damages are reasonably clear, an insurer shall not recommend that third-party claimants make claims under their own policies solely to avoid paying claims under the insurer's policy.

15.43(3) The insurer shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

15.43(4) The insurer shall, upon the claimant's request, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro-rata share of the allocated loss adjustment expense.

15.43(5) Vehicle repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount that will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate that the insured obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repair shops, the insurer shall ensure that the repairs are performed according to automobile industry standards. The insurer shall maintain documentation of all such communications.

15.43(6) When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

15.43(7) When the insurer elects to repair an automobile, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy, within a reasonable period of time.

15.43(8) Storage and towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges. The insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay all reasonable towing charges.

15.43(9) Betterment. Betterment deductions are allowable only if the deductions reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle. Betterment deductions must be measurable, itemized, specified as to dollar amount and documented in the claim file.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.44(507B) Standards for determining replacement cost and actual cost values.

15.44(1) *Replacement cost.* When the policy provides for the adjustment and settlement of first-party losses based on replacement cost, the following shall apply:

a. When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment or any other cost except for the applicable deductible.

b. When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace as much of the item as is necessary to result in a reasonably uniform appearance within the same line of sight. This subrule applies to interior and exterior losses. Exceptions may be made on a case-by-case basis. The insured shall not bear any cost over the applicable deductible, if any.

15.44(2) *Actual cash value.*

a. When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine the actual cash value. "Actual cash value" means replacement cost of property at time of loss, less depreciation, if any. Alternatively, an insurer may use market value in determining actual cash value. Upon the insured's request, the insurer shall provide a copy of the claim file worksheet(s) detailing any and all deductions for depreciation.

b. In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

15.44(3) *Applicability.* This rule does not apply to automobile insurance claims.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.45(507B) Guidelines for use of aftermarket crash parts in motor vehicles.

15.45(1) *Identification.* All aftermarket crash parts supplied for use in this state shall comply with the identification requirements of Iowa Code section 537B.4.

15.45(2) *Like kind and quality.* An insurer shall not require the use of aftermarket crash parts in the repair of an automobile unless the aftermarket crash part is certified by a nationally recognized entity to be at least equal in kind and quality to the original equipment manufacturer part in terms of fit, quality and performance, or that the part complies with federal safety standards.

15.45(3) *Contents of notice.* Any automobile insurance policy delivered in this state that pays benefits based on the cost of aftermarket crash parts or that requires the insured to pay the difference between the cost of original equipment manufacturer parts and the cost of aftermarket crash parts shall include a notice that contains and is limited to the following language:

NOTICE—PAYMENT FOR AFTERMARKET CRASH PARTS

Physical damage coverage under this policy includes payment for aftermarket crash parts. If you repair the vehicle using more expensive original equipment manufacturer (OEM) parts, you may pay the

difference. Any warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

15.45(4) *Form of notice.* Notice may be provided on a separate form or may be printed prominently on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application, but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the insurance division requires the notice in this rule.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.46 to **15.50** Reserved.

DIVISION III
DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

191—15.51(507B) Purpose. The purpose of these rules is to ensure the provision of meaningful information to the purchasers of small face amount life insurance policies. The rules in this division apply to all small face amount policies not exempted under rule 191—15.53(507B) that are issued on or after July 1, 2004.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.52(507B) Definition. *"Small face amount policy"* means a life insurance policy or certificate with an initial face amount of $15,000 or less.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.53(507B) Exemptions. These rules apply to all group and individual life insurance policies and certificates except:

1. Variable life insurance;
2. Individual and group annuity contracts;
3. Credit life insurance;
4. Group or individual policies of life insurance issued to members of an employer group or other permitted group when:
   - Every plan of coverage was selected by the employer or other group representative;
   - Some portion of the premium is paid by the group or through payroll deduction; and
   - Group underwriting or simplified underwriting is used; and
5. Policies and certificates where an illustration has been provided pursuant to the requirements of 191—Chapter 14.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.54(507B) Disclosure requirements.

15.54(1) An insurer issuing a small face amount policy shall provide the disclosure included in Appendix IV if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy, but may be delivered with the policy.

15.54(2) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

a. Provide the disclosure only in those circumstances when the premiums may exceed the face amount; or

b. Provide the disclosure for all demographic and benefit combinations.

15.54(3) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.55(507B) Insurer duties. The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.56 to **15.60** Reserved.

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

191—15.61(507B) Purpose. The purpose of the rules in Division IV of this chapter is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and to foster consumer education. The rules specify the minimum information that must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of these rules is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.62(507B) Applicability and scope. These rules apply to all annuities not exempted under this rule for which applications are taken on or after January 1, 2013, except that rule 191—15.66(507B) applies to all annuities not exempted under this rule that are in effect or for which applications are taken on or after January 1, 2013, and except that rule 191—15.67(507B) applies to all annuity contracts not exempted under this rule that are in effect on or after January 1, 2013. These rules apply to all group and individual annuity contracts and certificates except:

15.62(1) Immediate and deferred annuities that contain no nonguaranteed elements;

15.62(2) Annuities used to fund:

a. An employee pension plan that is covered by ERISA;

b. A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

c. A governmental or church plan defined in Section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

Notwithstanding this subrule, these rules shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pretax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subrule, "direct solicitation" shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

15.62(3) Structured settlement annuities;

15.62(4) Charitable gift annuities as defined in Iowa Code chapter 508F;

15.62(5) Nonregistered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.); and

15.62(6) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with rule 191—15.64(507B) shall be required after January 1, 2015, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

a. Notwithstanding this subrule, the delivery of the Buyer's Guide is required in sales of variable annuities and, when appropriate, in sales of other registered products.

b. Nothing in this subrule shall limit the commissioner's ability to enforce the provisions of these rules or to require additional disclosure.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.63(507B) Definitions. For purposes of these rules:

"Buyer's Guide" means the National Association of Insurance Commissioners' approved Annuity Buyer's Guide.

"Contract owner" means the owner named in the annuity contract or the certificate holder in the case of a group annuity contract.

"Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after the contract is issued. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

"Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

"Generic name" means a short title descriptive of the annuity contract for which application is made or an illustration is prepared, such as "single premium deferred annuity."

"Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

"Illustration" means a personalized presentation or depiction that is prepared for and provided to an individual consumer and that includes nonguaranteed elements of an annuity contract over a period of years.

"Market value adjustment" or *"MVA"* is a positive or negative adjustment that may be applied to the account value or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based either on the movement of an external index or on the company's current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

"Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges or elements of formulas used to determine any of these elements that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

"Structured settlement annuity" means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.64(507B) Standards for the disclosure document and Buyer's Guide.

15.64(1) *Delivery methods.* The documents required under this rule may be delivered as follows:

a. When an application for an annuity contract is taken in a face-to-face meeting, the applicant shall be given at or before the time of application both the disclosure document described in rule 191—15.65(507B) and the Buyer's Guide, if any.

b. When an application for an annuity contract is taken by means other than a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than five business days after the completed application is received by the insurer.

c. When an application is received as a result of direct solicitation through the mail:

(1) Providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five business days after receipt of the application.

(2) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

d. When an application is received via the Internet:

(1) Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five business days after receipt of the application.

(2) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

15.64(2) *Free Buyer's Guide.* A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the Iowa insurance division for a free Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free Buyer's Guide.

15.64(3) *Free-look period.* When the Buyer's Guide and disclosure document are not provided at or before the time of application, a free-look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or rule.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.65(507B) Content of disclosure documents.

15.65(1) At a minimum, the following information shall be included in the disclosure document required to be provided under these rules:

a. The generic name of the contract, the company product name, if different, and form number and the fact that it is an annuity;

b. The insurer's legal name, physical address, website address and telephone number;

c. A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, including but not limited to:

(1) The guaranteed and nonguaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(2) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(3) Periodic income options both on a guaranteed and nonguaranteed basis;

(4) Any value reductions caused by withdrawals from or surrender of the contract;

(5) How values in the contract can be accessed;

(6) The death benefit, if available, and how it will be calculated;

(7) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(8) Impact of any rider including, but not limited to, a guaranteed living benefit or a long-term care rider;

d. Specific dollar amount or percentage charges and fees, listed with an explanation of how they apply; and

e. Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

15.65(2) Insurers shall define terms used in the disclosure statement in language that facilitates understanding by a typical individual within the segment of the public to which the disclosure statement is directed.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.66(507B) Standards for annuity illustrations.

15.66(1) An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this rule and:

a. Is clearly labeled as an illustration;

b. Includes a statement referring consumers to the disclosure document and Buyer's Guide provided to them at time of purchase for additional information about their annuity; and

c. Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

15.66(2) An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

15.66(3) The illustration shall not be provided unless accompanied by the disclosure document referenced in rules 191—15.64(507B) and 191—15.65(507B).

15.66(4) When an illustration is used, the illustration shall not:

a. Describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

b. State or imply that the payment or amount of nonguaranteed elements is guaranteed; or

c. Be incomplete.

15.66(5) Costs and fees of any type shall be individually noted and explained in the illustration.

15.66(6) An illustration shall conform to the following requirements:

a. The illustration shall be labeled with the date on which it was prepared;

b. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");

c. The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

d. If the age of the proposed insured is shown as a component of the tabular detail, the age shown shall be issue age plus the numbers of years the contract is assumed to have been in force;

e. The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

f. Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features and indicating whether or not they are included in the illustration;

g. Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled as guaranteed;

h. Except as provided by paragraph 15.66(6)*"v,"* nonguaranteed elements underlying the nonguaranteed illustrated values shall be no more favorable than current nonguaranteed elements and shall not include any assumed future improvement of such elements. Additionally, nonguaranteed elements used in calculating nonguaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

i. In determining the nonguaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent 10 calendar years; one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of

the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:

(1) The most recent 10 calendar years and the last 20 calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(2) If any index utilized in determination of an account value has not been in existence for at least 10 calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least 10 calendar years, the allocation to such indexed account shall be assumed to be zero;

(3) If any index utilized in determination of an account value has been in existence for at least 10 calendar years but less than 20 calendar years, the 10-calendar-year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(4) The nonguaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the nonguaranteed index-based interest rate shall be no more favorable than the corresponding current elements;

(5) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

1. The allocation used in the illustration shall be the same for all three scenarios; and

2. The ten-calendar-year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option;

(6) The geometric mean annual effective rate of the account value growth over the ten-calendar-year period shall be shown for each scenario;

(7) If the most recent ten-calendar-year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subrule 15.66(8), the most recent ten-calendar-year historical period experience of the index shall be used for each subsequent 10-calendar-year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(8) The low and high scenarios:

1. Need not show surrender values (if different than account values);

2. Shall not extend beyond ten calendar years (and therefore are not subject to the requirements of subrule 15.66(8) beyond subparagraph 15.66(8)*"a"*(1)); and

3. May be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten-calendar-year period for the low scenario, the high scenario and the most recent ten-calendar-year scenario; and

(9) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

j. The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements (e.g., "see page 1 for guaranteed elements");

k. The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

l. The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

m. Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

n. Any illustration of nonguaranteed elements shall be accompanied by a statement indicating that:

(1) The benefits and values are not guaranteed;

(2) The assumptions on which they are based are subject to change by the insurer; and

(3) Actual results may be higher or lower;

o. Illustrations based on nonguaranteed credited interest and nonguaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and nonguaranteed participation rates, caps or spreads for fixed indexed annuities;

p. The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

q. Illustrations shall be concise and easy to read;

r. Key terms shall be defined and then used consistently throughout the illustration;

s. Illustrations shall not depict values beyond the maximum annuitization age or date;

t. Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable;

u. Illustrations shall show both annuity income rates per $1,000 and the dollar amounts of the periodic income payable; and

v. For participating immediate and deferred income annuities:

(1) Illustrations shall not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);

(2) Illustrations shall reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;

(3) If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;

(4) If the dividend scale is based on an investment cohort method, the illustrated dividend scale shall assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:

1. Any assumptions as to future investment performance in the dividend formula shall be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior. These assumptions shall not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and shall be consistent with assumptions that the insurer uses with respect to other lines of business.

2. The illustrated dividend scale shall assume that reinvestment rates grade to long-term interest rates, based on the rates of U.S. Treasury bonds (U.S. Treasury rates). For the purposes of this grading, the assumed long-term rates shall not exceed the rates calculated using the formula in numbered paragraph 15.66(6)*"v"*(4)"3" based on the time to maturity or reinvestment (the "tenor") of the investments supporting the cohort of policies.

3. Maximum long-term interest rates shall be calculated for tenors of 3 months or less, 5 years, 10 years, and 20 years or more, using U.S. Treasury rates. For each tenor, the maximum long-term interest rate shall vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median U.S. Treasury rate during the last 600 months and the average U.S. Treasury rate during the last 120 months, rounded to the nearest quarter of one percent (0.25%).

4. The maximum long-term interest rate for a tenor shall be recalculated once per year, in January, using historical interest rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical interest rate for each month is the interest rate reported for the last business day of the month.

5. Grading to the maximum long-term interest rates shall take place:

- No less than 20 years from the issue date if U.S. Treasury rates as of the illustration date are below the long-term interest rates; or

- No more than 20 years from the issue date if the U.S. Treasury rates as of the illustration date are above the long-term interest rates.

6. When the ten-year U.S. Treasury rate is less than the ten-year maximum long-term interest rate, an additional illustrated dividend scale shall be presented. This additional illustrated dividend scale shall satisfy the following conditions:

- Assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates, and
- Illustrate dividends of no less than half of the dividends illustrated under the current dividend scales.

If the conditions under the two prior bulleted paragraphs are in conflict (i.e., if half of the current dividends are greater than would be permitted by the condition under the first bulleted paragraph above), then the reinvestment U.S. Treasury rates shall equal the initial investment U.S. Treasury rates.

7. The illustration shall include a disclosure that is substantially similar to the following:

> The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current interest rates to long-term interest rates during a period of [20] years. As required by state regulations, the long-term assumed interest rates cannot and do not exceed the rates listed in column (c) of the table below.
> [Insert table from numbered paragraph 15.66(6)*"v"*(4)"9"]

8. If the illustration contains an additional dividend scale pursuant to numbered paragraph 15.66(6)*"v"*(4)"6," then the illustration also shall include a disclosure that is substantially similar to the following:

> The additional illustrated dividend scale is based on interest rates that are assumed not to increase and that do not exceed the interest rates in column (b) of the table below.
> [Insert table from numbered paragraph 15.66(6)*"v"*(4)"9"]

9. The following table shall be used in the disclosures as indicated in numbered paragraphs 15.66(6)*"v"*(4)"7" and "8":

(a)	(b)	(c)
	U.S. Treasury Rate as of 12/31/2016	**Long-Term U.S. Treasury Rate**
3 Months or Less	0.51%	3.00%
5 Years	1.93%	4.50%
10 Years	2.45%	5.00%
20 Years or More	3.06%	5.50%

15.66(7) An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:

a. A brief description of any contract features, riders or options, whether guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract.

b. A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract.

c. Identification and a brief definition of column headings and key terms used in the illustration.

d. A statement containing in substance the following:

(1) For other than fixed indexed annuities:

> This illustration assumes the annuity's current nonguaranteed elements will not change. It is likely that they **will** change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.
>
> The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information.

(2) For fixed indexed annuities:

This illustration assumes the index will repeat historical performance and that the annuity's current nonguaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index **will not** repeat historical performance, the nonguaranteed elements **will** change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information.

e. Additional explanations as follows:

(1) Minimum guarantees shall be clearly explained;

(2) The effect on contract values of contract surrender prior to maturity shall be explained;

(3) Any conditions on the payment of bonuses shall be explained;

(4) For annuities sold as an IRA or as a qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

(5) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur shall be included; and

(6) A brief description of the types of annuity income options available shall be explained, including:

1. The earliest or only maturity date for annuitization (as the term is defined in the contract);

2. For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age 70 or ten years after issue, but in no case later than the maximum annuitization age or date in the contract;

3. For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

4. The periodic income amount based on the currently available periodic income rates for the annuity income option in numbered paragraph 15.66(7)*"e"*(6)"2" or "3," if desired.

15.66(8) Following the narrative summary, an illustration shall include a numeric summary that shall include, at minimum, numeric values at the following durations:

a. Either:

(1) The first ten contract years; or

(2) The surrender charge period if longer than ten years, including any renewal surrender charge period;

b. Every tenth contract year up to the later of 30 years or age 70; and

c. Either:

(1) The required annuitization age; or

(2) The required annuitization date.

15.66(9) If the annuity contains a market value adjustment, hereafter MVA, all of the following provisions apply to the illustration (Appendix V provides an illustration of an annuity containing an MVA that addresses paragraphs 15.66(9)*"a"* through *"f"* below):

a. The MVA shall be referred to as such throughout the illustration.

b. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender.

c. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit.

d. A statement, containing in substance the following, shall be included:

When you make a withdrawal, the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount

you receive. If interest rates go down, the MVA will likely increase the amount you receive.

e. Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment.

f. The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of an MVA.

g. Actual MVA floors and ceilings as listed in the contract shall be illustrated.

h. If the MVA has significant characteristics not addressed by paragraphs 15.66(9)*"a"* through *"f,"* the effect of such characteristics shall be shown in the illustration.

15.66(10) A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

a. An explanation, in simple terms, of the elements used to determine the index-based interest, including, but not limited to, the following elements:

(1) The index(es) that will be used to determine the index-based interest;

(2) The indexing method – such as point-to-point, daily averaging, monthly averaging;

(3) The index term – the period over which indexed-based interest is calculated;

(4) The participation rate, if applicable;

(5) The cap, if applicable; and

(6) The spread, if applicable;

b. The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

c. The narrative shall include a brief description of the frequency with which the company can reset the elements used to determine the indexed-based credits, including the participation rate, the cap, and the spread, if applicable; and

d. If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(1) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

(2) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.

15.66(11) A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

a. The assumed growth rate of the index in accordance with paragraph 15.66(6)*"i"*;

b. The assumed values for the participation rate, cap and spread, if applicable; and

c. The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with paragraph 15.66(6)*"i."*

15.66(12) If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that nonsubstantive changes including, but not limited to, changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for, will not require a revised illustration unless requested by the applicant.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.67(507B) Report to contract owners. For annuities in the payout period that include nonguaranteed elements and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

15.67(1) The beginning and ending date of the current report period;

15.67(2) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

15.67(3) The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

15.67(4) The amount of outstanding loans, if any, as of the end of the current report period.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.68(507B) Penalties. In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of these rules shall be guilty of a violation of Iowa Code chapter 507B.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.69(507B) Severability. If any provision of these rules or the application of these rules to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rule and its application to other persons or circumstances shall not be affected.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.70 and **15.71** Reserved.

DIVISION V
SUITABILITY IN ANNUITY TRANSACTIONS

191—15.72(507B) Purpose. The purpose of these rules is to require producers, as defined in rule 191—15.74(507B), to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the times of the transactions are effectively addressed. Nothing herein shall be construed to create or imply a private cause of action for a violation of these rules or to subject a producer to civil liability under the best interest standard of care outlined in rule 191—15.75(507B) or under standards governing the conduct of a fiduciary or a fiduciary relationship.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.73(507B) Applicability and scope.

15.73(1) These rules shall apply to any sale or recommendation of an annuity on or after January 1, 2021.

15.73(2) Unless otherwise specifically included, these rules do not apply to transactions involving:

a. Direct-response solicitations where there is no recommendation based on information collected from the consumer pursuant to these rules;

b. Contracts used to fund the following:

(1) An employee pension or welfare benefit plan that is covered by ERISA;

(2) A plan described by Section 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC) if established or maintained by an employer;

(3) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC; or

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

c. Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

d. Formal prepaid funeral contracts.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.74(507B) Definitions. For purposes of this division:

"Annuity" means an annuity that is an insurance product under state law, individually solicited, whether the product is classified as an individual or group annuity.

"Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

"Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs and financial objectives, including, at a minimum, the following:

1. Age;
2. Annual income;
3. Financial situation and needs, including debts and other obligations;
4. Financial experience;
5. Insurance needs;
6. Financial objectives;
7. Intended use of the annuity;
8. Financial time horizon;
9. Existing assets or financial products, including investment, annuity and insurance holdings;
10. Liquidity needs;
11. Liquid net worth;
12. Risk tolerance, including, but not limited to, willingness to accept nonguaranteed elements in the annuity;
13. Financial resources used to fund the annuity; and
14. Tax status.

"Continuing education credit" or *"CE credit"* means one credit as defined in rule 191—11.2(505,522B).

"Continuing education provider" or *"CE provider"* means a CE provider as defined in rule 191—11.2(505,522B).

"FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

"Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.

"Material conflict of interest" means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation. "Material conflict of interest" does not include cash compensation or noncash compensation.

"Noncash compensation" means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

"Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

"Producer" means a person or entity required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. For purposes of these rules, "producer" includes an insurer where no producer is involved.

"Recommendation" means advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice. Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

"Replacement" means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer whether or not a producer is involved, that, by reason of the transaction, an existing annuity or other insurance policy has been or is to be any of the following:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

4. Reissued with any reduction in cash value; or

5. Used in a financed purchase.

"SEC" means the United States Securities and Exchange Commission.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.75(507B) Duties of insurers and producers.

15.75(1) *Best interest obligations.* A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer has acted in the best interest of the consumer if the producer has satisfied the following obligations regarding care, disclosure, conflict of interest and documentation:

a. Care obligation.

(1) The producer, in making a recommendation, shall exercise reasonable diligence, care and skill to:

1. Know the consumer's financial situation, insurance needs and financial objectives;

2. Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

3. Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

4. Communicate the basis or bases of the recommendation.

(2) The requirements under subparagraph 15.75(1)*"a"*(1) include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(3) The requirements under subparagraph 15.75(1)*"a"*(1) require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.

(4) The requirements under this subrule do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in these rules.

(5) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(6) The requirements under subparagraph 15.75(1)*"a"*(1) include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.

(7) The requirements under subparagraph 15.75(1)*"a"*(1) apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar product enhancements, if any.

(8) The requirements under subparagraph 15.75(1)*"a"*(1) do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(9) The requirements under subparagraph 15.75(1)*"a"*(1) do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

(10) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

1. The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

2. The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

3. The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(11) Nothing in this regulation should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

b. Disclosure obligation.

(1) Prior to the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to Appendix VI:

1. A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

2. An affirmative statement on whether the producer is licensed and authorized to sell the following products:

- Fixed annuities;
- Fixed indexed annuities;
- Variable annuities;
- Life insurance;
- Mutual funds;
- Stocks and bonds; and
- Certificates of deposit;

3. An affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:

- From one insurer;
- From two or more insurers; or
- From two or more insurers although primarily contracted with one insurer.

4. A description of the sources and types of cash compensation and noncash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary or other producer or by fee as a result of a contract for advice or consulting services; and

5. A notice of the consumer's right to request additional information regarding cash compensation described in subparagraph 15.75(1)*"b"*(2);

(2) Upon request of the consumer or the consumer's designated representative, the producer shall disclose:

1. A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and

2. Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and

(3) Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as: the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; mortality and expense fees; investment advisory fees; any annual fees; potential charges for and features of riders or other options of the annuity; limitations on interest returns; potential changes in nonguaranteed elements of the annuity; insurance and investment components; and market risk.

c. Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

d. Documentation obligation. A producer shall at the time of recommendation or sale:

(1) Make a written record of any recommendation and the basis for the recommendation subject to this regulation;

(2) Obtain a consumer-signed statement on a form substantially similar to Appendix VII documenting:

1. A customer's refusal to provide the consumer profile information, if any; and

2. A customer's understanding of the ramifications of not providing the customer's consumer profile information or providing insufficient consumer profile information; and

(3) Obtain a consumer-signed statement on a form substantially similar to Appendix VIII acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's recommendation.

e. Application of the best interest obligation. Any requirement applicable to a producer under this subrule shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

15.75(2) *Transactions not based on a recommendation.*

a. Except as provided under paragraph 15.75(2)*"b,"* a producer shall have no obligation to a consumer under paragraph 15.75(1)*"a"* related to any annuity transaction if:

(1) No recommendation is made;

(2) A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;

(3) A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or

(4) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.

b. An insurer's issuance of an annuity subject to paragraph 15.75(2)*"a"* shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

15.75(3) *Supervision system.*

a. Except as permitted under subrule 15.75(2), an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information.

b. An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with rules 191—15.72(507B) through 191—15.78(507B) including, but not limited to, the following:

(1) The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of these rules and shall incorporate the requirements of these rules into relevant producer training manuals;

(2) The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of rule 191—15.76(507B);

(3) The insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers;

(4) The insurer shall establish and maintain procedures for the review of each recommendation prior to issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(5) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with subrules 15.75(1), 15.75(2), 15.75(4) and 15.75(5). These procedures may include, but are not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations, and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures or by confirming the consumer profile information or other required information under this rule after issuance or delivery of the annuity;

(6) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this rule;

(7) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(8) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time; and

(9) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

c. Third-party supervisor.

(1) Nothing in this subrule restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subrule. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to rule 191—15.77(507B) regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph 15.75(3)*"c"*(2).

(2) An insurer's supervision system under this subrule shall include supervision of contractual performance under this subrule including, but not limited to, the following:

1. Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

2. Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

d. An insurer is not required to include in its system of supervision:

(1) A producer's recommendations to consumers of products other than the annuities offered by the insurer; or

(2) Consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

15.75(4) *Prohibited practices.* Neither a producer nor an insurer shall dissuade, or attempt to dissuade, a consumer from:

a. Truthfully responding to an insurer's request for confirmation of the consumer profile information;

b. Filing a complaint; or

c. Cooperating with the investigation of a complaint.

15.75(5) *Safe harbor.*

a. Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements under these rules. This subrule applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subrule shall limit the insurance commissioner's ability to investigate and enforce the provisions of these rules.

b. Nothing in paragraph 15.75(5)*"a"* shall limit the insurer's obligation to comply with paragraph 15.75(3)*"a,"* although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

c. For paragraph 15.75(5)*"a"* to apply, an insurer shall:

(1) Monitor the relevant conduct of the financial professional seeking to rely on paragraph 15.75(5)*"a"* or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal securities laws using information collected in the normal course of an insurer's business; and

(2) Provide to the entity responsible for supervising the financial professional seeking to rely on paragraph 15.75(5)*"a,"* such as the financial professional's broker-dealer or investment adviser registered under federal securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

d. For purposes of this subrule, "financial professional" means a producer that is regulated and acting as:

(1) A broker-dealer registered under federal securities laws or a registered representative of a broker-dealer;

(2) An investment adviser registered under federal securities laws or an investment adviser representative associated with the federal registered investment adviser; or

(3) A plan fiduciary under Section 3(21) of ERISA or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

e. For purposes of this subrule, "comparable standards" means:

(1) With respect to broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest and any amendments or successor regulations thereto;

(2) With respect to investment advisers registered under federal securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940, including, but not limited to, the Form ADV and interpretations; and

(3) With respect to plan fiduciaries or fiduciaries, means the duties, obligations, prohibitions and all other requirements attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.76(507B) Producer training.

15.76(1) A producer shall not solicit the sale of an annuity product unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with

the insurer's standards for product training. A producer may rely on insurer-provided product-specific training standards and materials to comply with this subrule.

15.76(2) Training required.

a. One-time course.

(1) A producer who engages in the sale of annuity products shall complete a one-time, four-credit training course approved by the commissioner and provided by an education provider approved by the commissioner.

(2) Producers may not engage in the sale of annuities until the annuity training course required under this rule has been completed.

b. The minimum length of the training required under this rule shall be sufficient to qualify for at least four CE credits, but may be longer.

c. The training required under this rule shall include information on the following topics:

(1) The types of annuities and various classifications of annuities;

(2) Identification of the parties to an annuity;

(3) How fixed, variable, indexed, and other product-specific annuity contract provisions affect consumers;

(4) The application of income taxation of qualified and nonqualified annuities;

(5) The primary uses of annuities;

(6) Appropriate standard of conduct sales practices; and

(7) Replacement and disclosure requirements.

d. Providers of courses intended to comply with this rule shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

e. A provider of an annuity training course intended to comply with this rule shall register as a CE provider in this state and comply with the rules and guidelines applicable to producer continuing education courses as set forth in 191—Chapter 11.

f. A producer who has completed an annuity training course approved by the commissioner prior to January 1, 2021, shall, before July 1, 2021, complete either:

(1) A new four-credit training course approved by the commissioner after January 1, 2021; or

(2) An additional one-time, one-credit training course approved by the commissioner and provided by the commissioner-approved education provider on appropriate sales practices, replacement and disclosure requirements under this amended regulation.

g. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with 191—Chapter 11.

h. Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with 191—Chapter 11.

i. Satisfaction of the training requirements of another state that are substantially similar to the provisions of this subrule shall be deemed to satisfy the training requirements of this subrule in this state.

j. The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subrule shall be deemed to satisfy the training requirements of this subrule in this state.

k. An insurer shall verify that a producer has completed the annuity training course required under this subrule before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subrule by obtaining certificates of completion of the training course or obtaining reports provided by Iowa insurance commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved continuing education providers.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.77(507B) Compliance; mitigation; penalties; enforcement.

15.77(1) An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its producer, the commissioner may order:

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with these rules by the insurer, an entity contracted to perform the insurer's supervisory duties, or by the producer;

b. A general agency, independent agency or the producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of the rules of this division; and

c. Appropriate penalties and sanctions.

15.77(2) Any applicable penalty under Iowa Code chapter 507B for a violation of the rules in Division V of this chapter may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

15.77(3) The authority to enforce compliance with these rules is vested exclusively with the commissioner.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.78(507B) Recordkeeping.

15.78(1) Insurers, general agents, independent agencies, and producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer (including summaries of oral disclosures) and other information used in making the recommendations that were the basis for insurance transactions for ten years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer.

15.78(2) Records required to be maintained by this rule may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.79 Reserved.

DIVISION VI
INDEXED PRODUCTS TRAINING REQUIREMENT

191—15.80(507B,522B) Purpose. The purpose of the rules in this division is to require certain specific minimum training for insurance producers who wish to sell indexed annuities or indexed life insurance in Iowa. This additional training is necessary due to the complex nature of these indexed products and to ensure that insurance producers are able to determine whether an indexed product is suitable for a consumer and are able to adequately explain to a consumer how the indexed product works. The ultimate goal of these rules is to ensure that purchasers of indexed products understand basic features of the indexed products. The rules in this division apply to all indexed products sold on or after January 1, 2008.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.81(507B,522B) Definitions. For the purpose of this division:

"CE credit" means one continuing education "credit" as defined in 191—Chapter 11.

"CE provider" means any individual or entity that is approved to offer continuing education courses in Iowa pursuant to 191—Chapter 11.

"Indexed products" means all fixed indexed life insurance and fixed indexed annuity products.

"Insurer" means an insurance company admitted to do business in Iowa that sells indexed products in Iowa.

"Producer" means a person required to obtain an insurance license under Iowa Code chapter 522B.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.82(507B,522B) Special training required. A producer who wishes to sell indexed products in Iowa shall complete at least one four-credit indexed products training course, as described in this division, prior to providing any advice or making any sales presentation concerning an indexed product.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.83(507B,522B) Conduct of training course.

15.83(1) The indexed products training shall include information on all topics listed in the most recent version of the indexed products training outline available at the division's website, iid.iowa.gov.

15.83(2) CE providers of indexed products training shall cover all topics listed in the indexed products training outline and, within the time allotted for the required topics, shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

15.83(3) The minimum length of the indexed products training must be sufficient to qualify for at least four CE credits but may be longer.

15.83(4) To satisfy the requirements of subrules 15.83(1), 15.83(2) and 15.83(3), an indexed products training course shall be filed, approved and conducted according to the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

15.83(5) Indexed products training courses may be conducted and completed by classroom or self-study methods according to the rules in 191—Chapter 11.

15.83(6) CE providers of indexed products training shall comply with the reporting requirements as set forth in 191—Chapter 11.

15.83(7) CE providers of indexed products training shall issue certificates of completion according to the rules in 191—Chapter 11.

15.83(8) A producer may use the CE credits completed under the indexed products training requirement to meet the producer's continuing education requirement under 191—Chapter 11.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.84(507B,522B) Insurer duties.

15.84(1) Each insurer shall establish a system to verify which of its appointed insurance producers have completed one training course on indexed products as required in this division.

15.84(2) An insurer shall verify that a producer has completed the required indexed products training before allowing the producer to sell an indexed product for that insurer.

15.84(3) For insurance producers under contract with or employed by a broker-dealer, general agent or independent agency, an insurer may enter into a contract with the broker-dealer, general agent or independent agency to establish and maintain a system of verification as required by subrule 15.84(1) with respect to those insurance producers. In such circumstances, the insurer shall make reasonable inquiry to ensure that the broker-dealer, general agent or independent agency is performing the functions required under subrules 15.84(1) and 15.84(2).
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.85(507B,522B) Verification of training. Insurers, producers and third-party contractors may verify a producer's completion of the indexed products training by accessing the division's website, iid.iowa.gov.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.86(507B,522B) Penalties.

15.86(1) Insurers and third-party contractors that violate the rules of this division are subject to penalty under Iowa Code chapter 507B.

15.86(2) Producers who violate the rules of this division are subject to penalty under Iowa Code chapters 507B and 522B.

15.86(3) Continuing education providers that fail to follow the requirements of the rules of this division and the conduct requirements of 191—Chapter 11 are subject to penalty under 191—Chapter 11 and Iowa Code chapters 507B and 522B.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

191—15.87(507B,522B) Compliance date.

15.87(1) A producer who provides advice or makes a sales presentation regarding an indexed product on or after January 1, 2008, shall have completed the indexed products training required by this division.

15.87(2) An Iowa-licensed insurer shall verify that, prior to the sale of any indexed products on or after January 1, 2008, any producer appointed by the insurer has completed the indexed products training required by this division.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX I
LIFE INSURANCE COST AND BENEFIT DISCLOSURE

Definitions.

"Annual premium" for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

"Cash dividend" means dividends that can be applied toward payment of gross premiums that comply with the illustrated scale.

"Equivalent level annual dividend" is calculated by applying the following steps:

1. Accumulate the annual cash dividends at 5 percent interest compounded annually to the end of the tenth and twentieth policy years.

2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207, and if the period is 20 years, the factor is 34.719.

3. Divide the results of paragraph "2" by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death other than suicide, or other specifically enumerated exclusions, at the beginning of each policy year for 10 and 20 years at 5 percent interest compounded annually to the end of the tenth and twentieth policy years, respectively.

2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207, and if the period is 20 years, the factor is 34.719.

"Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

"Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

1. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.

2. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at 5 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph "1."

3. Divide the result of subparagraph "2" (subparagraph "1" for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph "2" (subparagraph "1" for guaranteed-cost policies) over the respective periods stipulated in subparagraph "1." If the period is 10 years, the factor is 13.207, and if the period is 20 years, the factor is 34.719.

4. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5 percent interest compounded annually to the end of the period stipulated in subparagraph "1" and dividing the result by the respective factors stated in subparagraph "3" (this amount is the annual premium payable for a level premium plan).

5. Subtract the result of subparagraph "3" from subparagraph "4."

6. Divide the result of subparagraph "5" by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

"Policy summary," for the purposes of these rules, shall mean a written statement describing the elements of the policy including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

2. The name and address of the insurance producer or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

4. The generic name of the basic policy and each rider.

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide and other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values above.

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate.

7. Life insurance cost indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

9. A policy summary that includes dividends shall also include a statement that dividends are based on the company's illustrated scale and are not guaranteed and a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

11. The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph "5" of this definition shall be listed in total, not a per-thousand nor a per-unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each

insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.
[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX II
HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next ten years.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. Positive test results. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

a. False positives: This test gives a positive result, even though you are not infected. This happens rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

4. Side effects. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results become known to others. A negative result may create a false sense of security.

5. Disclosure of results. A positive test result will be reported to you in one of the following ways. You may choose to have information about a positive test result communicated to you through your physician or through the alternative testing site. If you do not designate a physician or an alternative testing site to receive the information, the information about a positive test result will be reported to the Iowa Department of Health and Human Services, and the Iowa Department of Health and Human Services will contact you.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by contacting the CDC national health information hotline, 1.800.CDC.INFO (1.800.232.4636); TTY 1.888.232.6348; www.cdc.gov/info.

INFORMED CONSENT

I hereby authorize the company and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure that is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.

a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the company.

2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.

b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If the third ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third blood or other bodily fluid test is negative, a negative result will be reported to the company.

3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as a positive. All other results will be reported as negative to the company.

Without a court order or written authorization from me, these results will be made known only to the company and its reinsurers (if involved in the underwriting process). The company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Screen will be disclosed only to my physician or an alternative testing site as I direct below. If I do not designate a physician or alternative testing site to receive the results, the company will provide results of a positive HIV test to the Iowa Department of Health and Human Services. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice that I received as a part of the application process. The only information the company will report to MIB, Inc., is that positive results were obtained from a blood or other bodily fluid test. The company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. Positive HIV Antibody Screen results are to be reported to: (elect one) □ the Alternative Testing Site or □ my physician: _____

(name and address of attending physician)

This authorization will be valid for 90 days from the date below.

Dated At: _____Day _____ Month _____, 20 _____

Witness: _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX III
COMPLAINT RECORD

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition after Complaint Received	Date Received	Date Closed	Insurance Division Complaint	State of Origin
(Producer's Number)								

Explanation

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number, name, or other means of identifying any licensee of the Insurance Division, such as a producer that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.
Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1) Underwriting
   a) Premium and rating
   b) Refusal to insure
   c) Cancellation/renewal
   d) Delays
   e) Unfair discrimination
   f) Endorsement/rider
   g) Group conversion
   h) Medicare supplement violation
   i) Miscellaneous (not covered by above)
2) Marketing and Sales
   a) General advertising
   b) Misrepresentation
   c) Producer handling
   d) Replacement
   e) Delays
   f) Miscellaneous (not covered by above)
3) Claims
   a) Post claim underwriting
   b) Delays
   c) Unsatisfactory settlement/offer
   d) Coordination of benefits
   e) Cost containment
   f) Denial of claim
   g) Miscellaneous (not covered by above)
4) Policyholder service
   a) Premium notice/billing
   b) Cash value
   c) Delays/no response
   d) Premium refund
   e) Coverage question
   f) Miscellaneous (not covered by above)
5) Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved as follows:
1) Automobile
2) Fire
3) Homeowners-Farmowners
4) Crop
5) Life and Annuity
6) Accident and Health
7) Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.
The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities:
1. Policy issued/restored.
2. Refund.
3. Claim settled.
4. Delay resolved.
5. Question of fact.
6. Contract provision/legal issue.
7. No jurisdiction.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the complaint was from an insurance department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

APPENDIX IV
DISCLOSURE FORM FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

Important Information About Your Policy

The premiums you'll pay for your policy may be more than the amount of your coverage (the face amount). You can find both the face amount and the annual premium in your policy. Look for the page labeled [use the label the company uses for that information, such as "Statement of Policy Cost and Benefit Information"].

- Usually, you can figure out how many years it will take until the premiums paid will be greater than the face amount. For an estimate, divide the face amount by the annual premium. Several factors may affect how many years this might take for *your* policy. These include not paying premiums when due, taking out a policy loan, surrendering your policy for cash, policy riders, payment of dividends, if applicable, and changes in the face amount.
- Many factors will affect how much your life insurance costs. Some are your age and health, the face amount of the policy, and the cost of a policy rider. You may be able to pay less for your insurance if you answer health questions. You may also pay less if you pay your premiums less often.
- Ask your insurance agent or your insurance company if you have any questions about your premiums, your coverage, or anything else about your policy.

If You Change Your Mind . . .

- You can get a full refund of premiums you've paid if you return your policy and cancel your coverage. You *must* do this within the number of days stated on your policy's front page. To return the policy for a full refund, send it back to the agent or the company.
- If you stop paying premiums or cancel your policy *after* the time that a full refund is available, you have specific rights. Ask your insurance agent or your insurance company about your rights.

Contact Information

If you have questions about your insurance policy, ask your agent or your company. If your agent isn't available, contact your insurance company at [provide telephone number (including toll-free number if available), address and website (if available)].

APPENDIX V

Annuity Illustration Example

[The following illustration is an example only and does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

(Contact us at Policyownerservice@ABCLife.com or 555.555.5555.)

Sex: Male	Initial Premium Payment: $100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate After Initial Interest Guarantee Period*:	3%

*After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:

- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for Annuitant's life with payments guaranteed for 10-year period.

Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/$1,000 of Account Value*	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	$164,798	$5.00	$823.99
Based on Rates Currently Offered by the Company	$171,976	$6.50	$1,117.84

*If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

(Contact us at Policyownerservice@ABCLife.com or 555.555.5555.)

		Values Based on Guaranteed Rates				Values Based on Assumption That Initial Guaranteed Rates Continue		
Contract Year/Age	Premium Payment	Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	$ 100,000	4.15%	$ 104,150	$ 95,818	$ 92,000	4.15%	$ 104,150	$ 95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,513
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

For column descriptions, turn to page 3

Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue.

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown.

Values Based on Guaranteed Rates

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your Initial Guaranteed Interest Rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

Values Based on Assumption That Initial Guaranteed Rates Continue

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as Column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case, the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take **no** withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

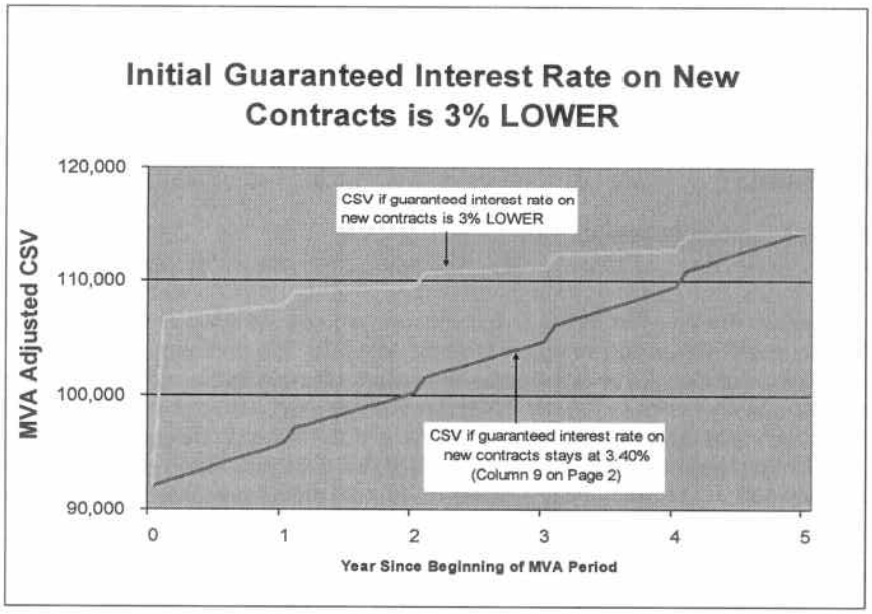
MVA-Adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

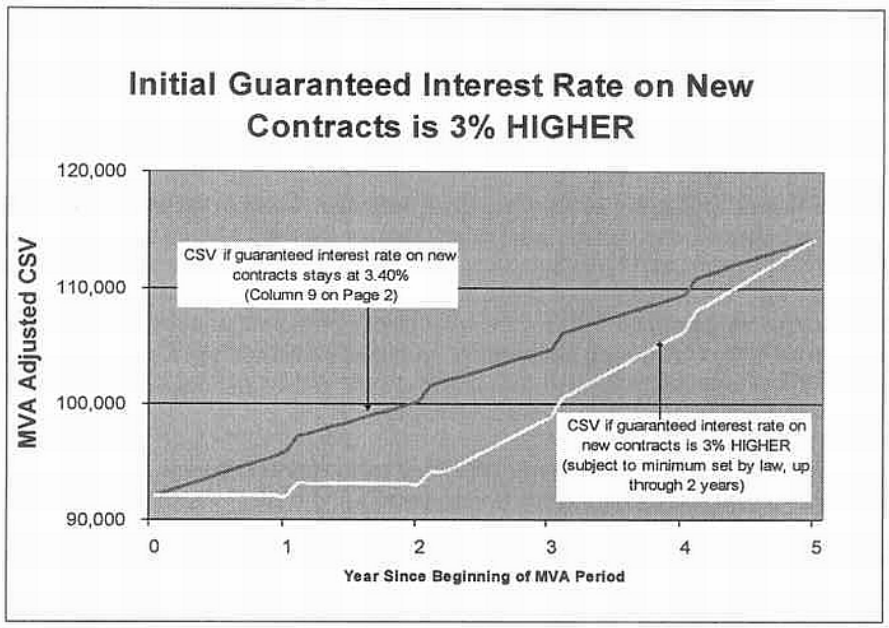
The graphs below* show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.





*Color not reproducible in the Iowa Administrative Code.

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX VI

INSURANCE AGENT (PRODUCER) DISCLOSURE FOR ANNUITIES

Do Not Sign Unless You Have Read and Understand the Information in this Form

Date:_____

INSURANCE AGENT (PRODUCER) INFORMATION ("Me", "I", "My")

First Name: _____ Last Name: _____

Business/Agency Name: _____ Website: _____

Business Mailing Address: _____

Business Telephone Number: _____

Email Address: _____

National Producer Number in [state]: _____

CUSTOMER INFORMATION ("You", "Your")

First Name: _____ Last Name: _____

What Types of Products Can I Sell You?

I am licensed to sell annuities to you in accordance with state law. If I recommend that You buy an annuity, it means I believe that it effectively meets Your financial situation, insurance needs, and financial objectives. Other financial products, such as life insurance or stocks, bonds and mutual funds, also may meet Your needs.

I offer the following products:

☐ Fixed or Fixed Indexed Annuities

☐ Variable Annuities

☐ Life Insurance

I need a separate license to provide advice about or to sell non-insurance financial products. I have checked below any non-insurance financial products that I am licensed and authorized to provide advice about or to sell.

☐ Mutual Funds

☐ Stocks/Bonds

☐ Certificates of Deposits

Whose Annuities Can I Sell to You?

I am authorized to sell:

☐ Annuities from Only One (1) Insurer	☐ Annuities from Two or More Insurers
☐ Annuities from Two or More Insurers although I primarily sell annuities from:	

How I'm Paid for My Work:

It's important for You to understand how I'm paid for my work. Depending on the particular annuity You purchase, I may be paid a commission or a fee. Commissions are generally paid to Me by the insurance company while fees are generally paid to Me by the consumer. If You have questions about how I'm paid, please ask Me.

Depending on the particular annuity You buy, I will or may be paid cash compensation as follows:

☐ Commission, which is usually paid by the insurance company or other sources. If other sources, describe: _____.

☐ Fees (such as a fixed amount, an hourly rate, or a percentage of your payment), which are usually paid directly by the customer.

☐ Other (Describe): _____.

If you have questions about the above compensation I will be paid for this transaction, please ask me.

I may also receive other indirect compensation resulting from this transaction (sometimes called "noncash" compensation), such as health or retirement benefits, office rent and support, or other incentives from the insurance company or other sources.

Drafting Note: *This disclosure may be adapted to fit the particular business model of the producer. As an example, if the producer only receives commission or only receives a fee from the consumer, the disclosure may be refined to fit that particular situation. This form is intended to provide an example of how to communicate producer compensation, but compliance with the regulation may also be achieved with more precise disclosure, including a written consulting, advising or financial planning agreement.*

Drafting Note: *The acknowledgment and signature should be in immediate proximity to the disclosure language.*

By signing below, you acknowledge that you have read and understand the information provided to you in this document.

_____

Customer Signature

_____

Date

_____

Agent (Producer) Signature

_____

Date

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX VII

CONSUMER REFUSAL TO PROVIDE INFORMATION

Do Not Sign Unless You Have Read and Understand the Information in this Form

Why are you being given this form?

You're buying a financial product – an annuity.

To recommend a product that effectively meets your needs, objectives and situation, the agent, broker, or company needs information about you, your financial situation, insurance needs and financial objectives.

If you sign this form, it means you have not given the agent, broker, or company some or all the information needed to decide if the annuity effectively meets your needs, objectives and situation. You may lose protections under the Insurance Code of [this state] if you sign this form or provide inaccurate information.

Statement of Purchaser:

☐ I **REFUSE** to provide this information at this time.

☐ I have chosen to provide LIMITED information at this time.

_____

Customer Signature

_____

Date

_____

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

APPENDIX VIII

Consumer Decision to Purchase an Annuity NOT Based on a Recommendation

Do Not Sign This Form Unless You Have Read and Understand It.

Why are you being given this form?

You are buying a financial product – an annuity.

To recommend a product that effectively meets your needs, objectives and situation, the agent, broker, or company has the responsibility to learn about you, your financial situation, insurance needs and financial objectives.

If you sign this form, it means you know that you're buying an annuity that was not recommended.

Statement of Purchaser:

I understand that I am buying an annuity, but the agent, broker or company did not recommend that I buy it. If I buy it **without a recommendation**, I understand I may lose protections under the Insurance Code of [this state].

_____

Customer Signature

_____

Date

_____

_____

Agent/Producer Signature

_____

Date

_____

[**ARC 7734C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapters 507B and 522B.

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[Filed ARC 5045C (Notice ARC 4998C, IAB 3/25/20), IAB 6/3/20, effective 1/1/21][4]
[Filed ARC 6119C (Notice ARC 6015C, IAB 11/3/21), IAB 12/29/21, effective 2/2/22]
[Filed ARC 7734C (Notice ARC 7349C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

◊ Two or more ARCs

1 The Administrative Rules Review Committee at their February 13, 1979, meeting delayed the effective date of rules 15.90 to 15.93 seventy days.

2 Effective date (12/31/81) of rules 15.9 and 15.31 delayed 70 days by the Administrative Rules Review Committee.

3 At its meeting held August 13, 2003, the Administrative Rules Review Committee voted to delay the effective date of 15.43(10) until adjournment of the 2004 Session of the General Assembly.

4 The effective date of **ARC 5045C** was corrected to January 1, 2021, in the June 17, 2020, Iowa Administrative Bulletin.

CHAPTER 16
REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

[Prior to 10/22/86, Insurance Department[510]]

DIVISION I

191—16.1 to **16.20** Reserved.

DIVISION II

(Effective July 1, 2000)

191—16.21(507B) Purpose.

16.21(1) The purpose of these rules is:

a. To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.

b. To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions by:

(1) Ensuring that purchasers receive information with which a decision can be made in the purchaser's own best interest;

(2) Reducing the opportunity for misrepresentation and incomplete disclosure; and

(3) Establishing penalties for failure to comply with requirements of these rules.

16.21(2) These rules are authorized by Iowa Code section 507B.12 and are intended to implement Iowa Code section 507B.4.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.22(507B) Definitions.

"Commissioner" means the Iowa insurance commissioner.

"Contract" means an individual annuity contract.

"Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

"Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

"Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

"Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from, values of an existing policy to pay all or part of any premium due on a new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender, or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company, within 4 months before or 13 months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to purchase the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in paragraph 16.25(1)*"e."*

"Illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years as defined in 191—Chapter 14.

"Policy" means an individual life insurance policy.

"Policy summary," for the purposes of these rules, means:

1. For policies or contracts other than universal life policies, a written statement regarding a policy or contract that shall contain to the extent applicable, but need not be limited to, the following information: current death benefit, annual contract premium, current cash surrender value, current dividend, application of current dividend, and amount of outstanding loan.

2. For universal life policies, a written statement that shall contain at least the following information: the beginning and end date of the current report period; the policy value at the end of the previous report period and at the end of the current report period; the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders); the current death benefit at the end of the current report period on each life covered by the policy; the net cash surrender value of the policy as of the end of the current report period; and the amount of outstanding loans, if any, as of the end of the current report period.

"Producer" means a person licensed under Iowa Code chapter 522B.

"Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

"Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

4. Reissued with any reduction in cash value; or

5. Used in a financed purchase.

"Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

"Sales material" means a sales illustration and any other written, printed or electronically presented information created, completed or provided by the company or producer that is used in the presentation to the policy or contract owner related to the policy or contract that is purchased.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.23(507B) Exemptions.

16.23(1) Unless otherwise specifically included, these rules shall not apply to transactions involving:

a. Credit life insurance.

b. Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct-response solicitation shall be subject to the provisions of rule 191—16.28(507B).

c. Group life insurance and annuities used to fund formal prepaid funeral contracts.

d. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner.

e. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

f. Except as noted below, policies or contracts used to fund:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(3) A governmental or church plan defined in Section 414 of the Internal Revenue Code, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the Internal Revenue Code; or

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

These rules shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pretax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more annuity providers or policy providers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy.

g. New coverage provided under a life insurance policy or contract where the cost is borne wholly by the insured's employer or by an association of which the insured is a member.

h. Existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed.

i. Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this chapter.

j. Structured settlement annuities.

16.23(2) Registered contracts shall be exempt from the requirements of paragraph 16.26(1)*"b"* and subrule 16.27(2) with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.24(507B) Duties of producers.

16.24(1) A producer who initiates an application for a policy or a contract shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the applicant does not have an existing policy or contract, the producer's duties with respect to replacement are complete.

16.24(2) If the applicant does have an existing policy or contract, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the commissioner.

a. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and that a copy of the notice was left with the applicant.

b. The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

16.24(3) In connection with a replacement transaction, the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. A copy of any electronically presented sales material shall be provided to the policyholder in printed form no later than at the time of policy or contract delivery.

16.24(4) Except as provided in subrule 16.26(3), in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented a copy of each document required by this subrule, a statement identifying any preprinted or electronically presented insurer-approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.25(507B) Duties of all insurers that use producers on or after January 1, 2001.

16.25(1) Each insurer that uses producers shall maintain a system of supervision and control to ensure compliance with the requirements of these rules that shall include at least the following:

a. Informing its producers of the requirements of these rules and incorporating the requirements of these rules into all relevant producer training manuals prepared by the insurer;

b. Providing to each producer a written statement of the insurer's position with respect to the acceptability of replacements, including providing guidance to its producer as to the appropriateness of these transactions;

c. Reviewing the appropriateness of each replacement transaction that the producer does not indicate is in accord with paragraph 16.25(1)*"b"*;

d. Confirming that the requirements of these rules have been met; and

e. Detecting transactions that are replacements of existing policies or contracts by the existing insurer but that have not been reported as such by the applicant or producer. Compliance with this subrule may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters or programs of internal monitoring.

16.25(2) Each insurer that uses producers shall have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer and shall, upon request, make such records available to the insurance division. The capacity to monitor shall include the ability to produce records for each producer's:

a. Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

b. Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

c. Annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

d. Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the insurer's monitoring system as required by paragraph 16.25(1)*"e"*; and

e. Replacements, indexed by replacing producer and existing insurer.

16.25(3) Each insurer that uses producers shall require with or as a part of each application for life insurance or for an annuity a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts.

16.25(4) Each insurer that uses producers shall require with each application for life insurance or for an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in Appendix A.

16.25(5) When the applicant has existing policies or contracts, each replacing insurer that uses producers shall be able to produce completed and signed copies of the notice regarding replacements for at least five years after the termination or expiration of the proposed policy or contract.

16.25(6) In connection with a replacement transaction, each replacing insurer that uses producers shall be able to produce copies of any sales material required by subrule 16.24(4), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased and the producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract.

16.25(7) Each insurer that uses producers shall ascertain that the sales material and illustrations required by subrule 16.24(4) meet the requirements of these rules and are complete and accurate for the proposed policy or contract.

16.25(8) If an application does not meet the requirements of these rules, each insurer that uses producers shall notify the producer and applicant and fulfill the outstanding requirements.

16.25(9) Records required to be retained by this rule may be maintained by any process that accurately reproduces the actual document.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.26(507B) Duties of replacing insurers that use producers.

16.26(1) Where a replacement is involved in the transaction, the replacing insurer that uses producers shall:

a. Verify that the required forms are received and are in compliance with these rules;

b. Notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer;

c. Be able to produce copies of the notification regarding replacement required in subrule 16.24(2), indexed by producer, for at least five years or until the next regular examination by the insurance department of an insurer's state of domicile, whichever is later; and

d. Provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract. The notice may be included in Appendix A or C.

16.26(2) Where a replacement is involved in the transaction and where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract.

16.26(3) Where a replacement is involved in the transaction and where an insurer prohibits the use of sales material other than that approved by the insurer, the insurer may, as an alternative to the requirements of subrule 16.24(4) do all of the following:

a. Require of and obtain from the producer a signed statement with each application that:

(1) Represents that the producer used only insurer-approved sales material; and

(2) Represents that copies of all sales material were left with the applicant in accordance with subrule 16.24(3).

b. Provide the following to the applicant by a letter or by verbal communication, by a person whose duties are separate from the marketing area of the insurer, within ten days of the issuance of the policy or contract:

(1) Information that the producer has represented that copies of all sales material have been left with the applicant in accordance with subrule 16.24(3);

(2) The toll-free number by which the applicant can contact company personnel involved in the compliance function if copies of all sales material were not left with the applicant; and

(3) Information regarding the importance of retaining copies of the sales material for future reference.

c. Be able to produce a copy of the letter or other verification obtained pursuant to this subrule in the policy file for at least five years after the termination or expiration of the policy or contract.

[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.27(507B) Duties of the existing insurer. Where a replacement is involved in the transaction, the existing insurer shall:

16.27(1) Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the insurance department of its state of domicile, whichever is later.

16.27(2) Send a letter to the policy or contract owner notifying the owner of the right to receive information regarding the existing policy or contract values including, if available, an in-force illustration or policy summary if an in-force illustration cannot be produced within five business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within five business days of receipt of the request from the policy or contract owner.

16.27(3) Upon receipt of a request to borrow, surrender or withdraw any policy values, send to the applicant a notice, advising the policyowner that the release of policy values may affect the guaranteed elements, nonguaranteed elements, face amount or surrender value of the policy from which the values

are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policyowner.
[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.28(507B) Duties of insurers with respect to direct-response solicitations.

16.28(1) In the case of an application that is initiated as a result of a direct-response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, the notice regarding replacement in Appendix B, or other substantially similar form approved by the commissioner.

16.28(2) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

a. Provide to applicants or prospective applicants with the policy or contract a notice, as described in Appendix C, or other substantially similar form approved by the commissioner. In these instances, the insurer may delete the references to the producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if the insurer can demonstrate that the insurer has made a diligent effort to secure a signed copy of the notice referred to in this paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed, postage prepaid envelope with instructions for the return of the signed notice referred to in this subrule; and

b. Comply with the requirements of paragraph 16.26(1)*"b,"* if the applicant furnishes the names of the existing insurers, and the requirements of paragraphs 16.26(1)*"c"* and *"d"* and subrule 16.26(2).
[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.29(507B) Violations and penalties.

16.29(1) Any failure to comply with these rules shall be considered a violation of rules 191—15.7(507B) and 191—15.8(507B). Examples of violations include but are not limited to:

a. Any deceptive or misleading information set forth in sales material;

b. Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

c. The intentional incorrect recording of an answer;

d. Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

e. Advising a policy or contract owner to write directly to the insurer in such a way as to attempt to obscure the identity of the replacing producer or insurer.

16.29(2) Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate these rules.

16.29(3) Where it is determined that the requirements of these rules have not been met, the replacing insurer shall provide to the policy owner an in-force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the appropriate notice regarding replacements in Appendix A or C.

16.29(4) Violations of these rules shall subject the violators to penalties that may include the revocation or suspension of a producer's or insurer's license, monetary fines, the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which

the violations occurred, or any other penalties authorized by Iowa Code chapter 507B or 191—Chapter 15.
[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

191—16.30(507B) Severability. If any rule or portion of a rule of this division, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this division, or the applicability of its provisions to other persons, shall not be affected.
[**ARC 7735C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapter 507B.

APPENDIX A

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name	Date
Producer's Signature and Printed Name	Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:	Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
POLICY VALUES:	New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?
INSURABILITY:	If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. [Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

APPENDIX B

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

APPENDIX C

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:	Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
POLICY VALUES:	New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?
INSURABILITY:	If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. [Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE

[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
FORM AND RATE REQUIREMENTS

191—20.1(505,509,514A,515,515A,515F) General requirements for filing rates and forms.

20.1(1) Insurers required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Insurers must comply with the division's requirements for submissions, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set out on the SERFF website at serff.com.

20.1(2) No rate filing shall include any adjustment designed to recover underwriting or operating losses incurred out of state. Upon request by the commissioner, insurers doing business in Iowa shall segregate in their rate filings data from any state identified by the commissioner, and the filings shall include a certification that no portion of any rate increase is designed to recover underwriting or operating losses incurred in another state.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.2(505) Objection to form filing.

20.2(1) Any insured or established organization with one or more insureds among its members that has an objection to a form filing may submit to the insurance commissioner a written request for a hearing on the filing. A request for a hearing must be filed within 20 days after the filing has been received by the commissioner.

20.2(2) Within 20 days after receipt of the request for a hearing, the commissioner will hold a hearing to consider the objection to the filing. The commissioner will provide not less than ten days' written notice of the time and place of the hearing to the person or association filing the request, to the filing insurer or organization, and to any other person requesting notice. The commissioner may suspend or postpone the effective date of the filing pending the hearing. Upon consideration of the information received at the hearing, the commissioner may determine whether or not to approve the filing.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.3 Reserved.

191—20.4(505,509,514A,515,515A,515F) Policy form filing.

20.4(1) Each policy form, endorsement, application and agreement modifying the provisions of policies must bear an identification form number. This form number must be in the lower left-hand corner unless uniform or authentic forms are used.

20.4(2) Reserved.

20.4(3) A form filing that has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from the date that all necessary requirements are submitted to SERFF.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.5(515A) Rate or manual rule filing.

20.5(1) Every insurer shall determine and file its final rates with the commissioner pursuant to provisions of Iowa Code chapter 515F, except for insurers of workers' compensation that are specifically excluded by Iowa Code section 515F.3(2) and residual market mechanisms.

a. Advisory organizations, defined in Iowa Code section 515F.2 and licensed pursuant to Iowa Code section 515F.8, may file on behalf of their member and subscriber companies prospective loss costs, supplementary rating information and supporting information as defined in Iowa Code section 515F.2.

Advisory organization filings shall be filed and made effective in accordance with the provisions of Iowa Code sections 515F.4 through 515F.6 or 515F.23 through 515F.25 that apply to the filing and approval of rates and supplementary rating information.

b. An insurer may satisfy its obligation to make rate filings and supplementary rating information by becoming a participating insurer of a licensed advisory organization that makes reference filings of advisory prospective loss costs and by authorizing the commissioner to accept such filings on its behalf, subject to any modifications filed by the insurer. The insurer's rates shall be the prospective loss costs filed by the advisory organization that have been put into effect in accordance with paragraph 20.5(1)*"a,"* combined with the loss cost adjustments that are filed in accordance with paragraph 20.5(1)*"a."*

c. If an insurer has previously filed forms modifying coverage provided by the applicable advisory organization forms, such fact should be noted in the rate filing.

20.5(2) Rate filings shall reflect that due consideration has been given to the factors enumerated in Iowa Code section 515F.4(1), and shall be accompanied by supporting statistical exhibits. In addition, each filing shall note the date of the last revision of rates affecting this coverage and briefly describe the nature of that revision. Such filings shall identify each page filed by placing their own name thereon.

20.5(3) If a company filing rates used the manuals of an advisory organization in its filings, any portion of the manuals of the advisory organization that will not be followed by the filing must be clearly shown as deleted or amended by use of an appropriately numbered exception page.

20.5(4) For residual market mechanisms, insurers making filings on their own behalf shall identify the submission as an independent filing or a deviation from the previously filed form, rate, or rule. A deviation filing is a submission that represents modification of a form or rate or rule previously filed by an authorized rating organization or advisory organization on behalf of its member and subscriber companies. An insurer shall note in its filing if it has previously filed forms modifying coverage provided by the applicable standard forms.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.6(515A) Exemption from rate filing requirement.

20.6(1) An insurer requesting, pursuant to Iowa Code section 515F.5(4), suspension or modification of the requirement of filing of a rate shall provide the commissioner with a full explanation for the proposed exemption from the filing requirement together with any actuarial data available and shall furnish the commissioner with any additional material the commissioner may desire.

20.6(2) If the commissioner finds that a proposed rate represents a classification for which credible and homogeneous statistical experience does not exist and cannot be analyzed using standard actuarial techniques to produce a statistically significant average rate for the individual risks within the classification, the commissioner may exempt the insurer from the filing requirement for that proposed rate.

20.6(3) An insurer shall maintain statistical records of the experience and expenses attendant upon the risks covered by any rate exempted by the commissioner from the filing requirement. The insurer may supplement statistical information filed with the commissioner with information by an advisory organization licensed pursuant to Iowa Code section 515F.8.

This rule is intended to implement Iowa Code section 515A.4(6).

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.7 Reserved.

191—20.8(515F) Rate filings for crop-hail insurance. Rate filings for crop-hail insurance shall be submitted on or before January 31 of each calendar year. Each company may file one set of rates per policy plan per calendar year that shall remain in effect throughout the current crop year. In the absence of a new filing, rates on file from the previous year will remain in effect. Each filing shall be accompanied by a cover letter, synopsis sheet and supporting data that justify the filed rate.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.9 and **20.10** Reserved.

191—20.11(515) Exemption from form and rate filing requirements.

20.11(1) The following lines of insurance shall be exempt from the form filing requirements of Iowa Code section 515.102:

a. Aircraft hull and aviation liability.
b. Difference-in-conditions.
c. Kidnap-ransom.
d. Manuscript policies and endorsements issued to not more than two insureds in Iowa.
e. Political risk.
f. Reinsurance.
g. Terrorism.
h. War risk.
i. Weather insurance.

20.11(2) An insurer shall, within 30 days of the commissioner's request, provide the commissioner with any of the information that is exempted from form and rate filing requirements.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapter 515F and section 515.109.

191—20.12 to **20.40** Reserved.

DIVISION II
IOWA FAIR PLAN ACT

191—20.41(515,515F) Purpose. This division is intended to implement and interpret Iowa Code sections 515F.30 through 515F.38 for the purpose of establishing procedures and requirements for a mandatory risk-sharing facility for basic property insurance coverage. This division is also intended to encourage improvement of and reasonable loss prevention measures for properties located in Iowa and to further orderly community development.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.42(515,515F) Scope. This division shall apply to all insurers licensed to write property insurance in Iowa.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.43(515,515F) Definitions. In addition to the definitions in Iowa Code sections 514F.2 and 515F.32 and rule 191—20.1(505,509,514A,515,515A,515F), the following definitions apply:

"Location" means a single building and its contents, or contiguous buildings and their contents, under one ownership.

"Manufacturing risks" means those risks eligible to be written under the customary manufacturing business interruption policy forms approved by the commissioner. The following are not considered manufacturing risks:

1. Dry cleaning and laundering—Carpet, rug, furniture, or upholstery cleaning; diaper service or infants' apparel laundries; dry cleaning; laundries; linen supply.
2. Installation, servicing and repair—Electrical equipment; electronic equipment; glazing; household furnishings and appliances; office machines; plumbing, heating and air conditioning; protective systems for premises, vaults and safes.
3. Laboratories—Blood banks; dental laboratories; medical or X-ray laboratories.
4. Duplicating or similar services—Blueprinting and photocopying services; bookbinding; electrotyping; engraving; letter service (mailing or addressing companies); linotype or hand composition; lithographing; photo engraving; photo finishing; photographers (commercial).
5. Warehousing—Cold storage (locker establishments); cold storage warehouse; furniture or general merchandise warehouse.
6. Miscellaneous—Barber shops; beauty parlors; cemeteries; dog kennels; electroplating; equipment rental (not contractors' equipment); film and tape rental; funeral directors; galvanizing, tinning, and detinning; radio broadcasting, commercial wireless and television broadcasting;

taxidermists; telephone or telegraph companies; textiles (bleaching, dyeing, mercerizing or finishing of property of others); veterinarians and veterinary hospitals.

"Motor vehicles" means vehicles that are self-propelled.

"Weighted premiums written" means:

1. Gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to property in this state excluding premiums on risks insured under the Iowa FAIR Plan association, for basic property insurance, for homeowners multiple peril policies, for farm dwelling policies and for the basic property insurance premium components of all other multiple peril policies.

2. In addition, 100 percent of the premiums obtained for homeowners multiple peril policies shall be added to 100 percent of the premiums obtained for basic property insurance and the basic property insurance premium components of all other multiple peril policies. The basic year for the computation shall be the first preceding calendar year.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.44(515,515F) Eligible risks. All risks at a fixed location shall be eligible for inspection and considered for insurance under the Plan except motor vehicles, inland marine risks, and manufacturing risks as defined above.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.45(515,515F) Membership. Every insurer licensed to write one or more components of basic property insurance shall be considered a member of the Plan. Any other insurer may, upon application to and approval by the governing committee, become a member.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.46(515,515F) Administration.

20.46(1) The Plan shall be administered by the governing committee, subject to supervision of the commissioner, and operated by a manager appointed by the governing committee.

20.46(2) The governing committee shall consist of seven members, each of whom shall serve for a period of one year or until a successor is elected or designated. Each member shall have one vote.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.47(515,515F) Duties of the governing committee.

20.47(1) The governing committee shall meet as often as may be required to perform the general duties of the administration of the Plan, or at the call of the commissioner. Four members of the committee present or by proxy shall constitute a quorum. Members of the committee who choose to appoint a proxy shall give a written proxy to the person elected to act as proxy. The written proxy shall then be filed with the governing committee, thus ensuring the validity of the proxy's actions as the governing committee performs its duties.

20.47(2) The governing committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds, and perform all other duties of the Plan. The adoption of or substantive changes in pension plans or employee benefit programs for the manager and staff shall be subject to approval of the governing committee.

20.47(3) The governing committee may designate an independent inspection firm to make inspections as required under the Plan and to perform such other duties as may be authorized by the governing committee.

20.47(4) The governing committee shall submit to the commissioner periodic reports setting forth information as the commissioner may request. On or before April 1 of each year, the governing committee shall submit a report summarizing any new programs or reforms in operation undertaken during the preceding calendar year in order to comply with any new legislation, regulations or directives affecting the Plan. This report shall contain a statistical tabulation on business written in accordance with the Plan.

20.47(5) The governing committee shall separately code all policies written by the Plan so that appropriate records may be compiled for purposes of performing loss prevention and other studies of the operation of the Plan.

20.47(6) The governing committee shall authorize the manager to file rates, surcharge schedules and forms for prior approval by the commissioner.

20.47(7) The governing committee shall prepare such agreements and contracts as may be necessary for the execution of this division consistent with its provisions.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.48(515,515F) Annual and special meetings.

20.48(1) There shall be an annual meeting of the insurers on a date fixed by the governing committee at which time members may be chosen.

20.48(2) A special meeting shall be called by the governing committee within 40 days after receipt of written request from any ten insurers, not more than one of which may be in a group under the same management or ownership.

20.48(3) The time and place of all meetings shall be reasonable. Twenty days' notice of an annual or special meeting shall be given in writing by the governing committee to all insurers defined above. Four members present in person or by proxy shall constitute a quorum. Voting by proxy shall be permitted.

20.48(4) Any matter not inconsistent with the law or this division may be proposed and voted upon at any special meeting of the committee. Notice of any such proposal shall be mailed to each insurer not less than 20 days prior to the final date fixed by the committee for voting thereon.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.49(515,515F) Application for insurance.

20.49(1) Any person who has an insurable interest in an eligible risk in property permitted to be written in the Plan and who has received within the last six months a notice of rejection, nonrenewal or cancellation from an insurer may apply for insurance by the Plan.

20.49(2) An inspection need not be made if the governing committee determines that insurance can be provided for specified classes of risks on the basis of representations of the applicant or insurance producer.

20.49(3) The Plan may bind coverage. The Plan may wait until receipt of the inspection report or receipt of additional underwriting information before determining whether to bind coverage. Coverage will be bound by the Plan by acknowledgement to the producer.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.50(515,515F) Inspection procedure.

20.50(1) The inspection by the Plan shall be without cost to the applicant.

20.50(2) The manner and scope of the inspection shall be prescribed by the Plan with the approval of the commissioner.

20.50(3) An inspection report shall be made for each property inspected covering pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. Representative photographs may be taken during the inspection to indicate the pertinent features of building, construction, maintenance, occupancy, and surrounding property.

20.50(4) After the inspection, a copy of the completed inspection report and any relevant photographs shall be kept on file by the Plan. The report shall include a description of any deficient physical condition changes proposed by the inspector. A copy of the inspection report shall be made available to the applicant or producer upon request.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.51(515,515F) Procedure after inspection and receipt of application.

20.51(1) After receipt of the application, the inspection report, and any additional underwriting information requested from the applicant, the Plan shall within five business days complete and send to the applicant an action report advising the applicant of one of the following:

a. That the risk is acceptable. If the inspection reveals substandard conditions, appropriate charges may be imposed, but the report shall specify the improvements necessary for removal of each such charge.

b. That the risk is declined unless reasonable improvements noted in the action report are made by the applicant and confirmed by reinspection.

c. That the risk is declined because the risk fails to meet reasonable underwriting standards as set forth in rule 191—20.52(515,515F). Reasonable underwriting standards as set forth in rule 191—20.52(515,515F) shall not include neighborhood or area location or any environment hazard beyond the control of the property owner.

20.51(2) If the risk is accepted, the action report shall advise the applicant of:

a. The amount of coverage the Plan agrees to write.

b. The amount of coverage the Plan agrees to write if specified improvements are made.

c. The amount of coverage the Plan agrees to write only if a large or special deductible is agreed to by the applicant.

20.51(3) If the risk is accepted, the Plan, upon receipt of the premium, shall deliver the policy to the applicant or to the licensed producer designated by the applicant for delivery to the applicant. The Plan shall remit the commissions to the licensed producer designated by the applicant.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.52(515,515F) Reasonable underwriting standards for property coverage.

20.52(1) The following characteristics may be used in determining whether a risk is acceptable for property coverage. Where there is more than one cause for declination, all causes shall be listed and complied with before the property may be accepted for insurance purposes.

a. Physical condition of property; however, the mere fact that a property does not satisfy all current building code specifications will not, of itself, suffice as a reason for declination.

b. The property's present use as extended vacancy or extended unoccupancy of the property for 60 consecutive days. Properties that are vacant or unoccupied for more than 60 days may be insured while rehabilitation or reconstruction work is actively in process, meaning that the insured or owner should make monthly progress in order to complete the rehabilitation or reconstruction within a one-year time frame.

c. Other specific characteristics of ownership, condition, occupancy or maintenance that violate the law and that result in substantial increased exposure to loss. Any circumstance considered under this paragraph must relate to the peril insured against.

d. Physical condition of buildings that results in an outstanding order to vacate, in an outstanding demolition order or in being declared unsafe in accordance with the applicable law.

e. One or more of the conditions for nonrenewal as listed in rule 191—20.54(515,515F) currently exist. The Plan shall upon notice that conditions at the buildings have changed consider a new application for coverage.

f. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

g. Any other guidelines that have been approved by the commissioner.

20.52(2) Reserved.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.53(515,515F) Reasonable underwriting standards for liability coverage.

20.53(1) The following characteristics may be used in determining whether a risk is acceptable for liability insurance on homeowner policies:

a. Broken, cracked, uneven or otherwise faulty steps, porches, decks, sidewalks, patios and similar areas.

b. Downspouts or drains that discharge onto sidewalks or driveways.

c. Unsafe conditions including inadequate lighting of stairways.

d. Animals known to be vicious or animals that have caused a liability claim.

e. Swimming pools or private ponds not fenced in accordance with local regulations.

f. Unsafe, or the absence of, handrails.

g. Junk cars, empty refrigerators, trampolines or other potentially dangerous objects in the yard that are an attraction to children.

h. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

i. Any other guidelines that have been approved by the commissioner.

20.53(2) Liability insurance shall only be provided as contained in the Iowa FAIR Plan homeowners policy.

20.53(3) Liability insurance shall not be provided for risks with any of the deficiencies set forth in paragraphs 20.53(1)*"a"* through *"g,"* as disclosed by the application or inspection, until the deficiencies have been corrected.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.54(515,515F) Cancellation; nonrenewal and limitations; review of eligibility.

20.54(1) The Plan shall not cancel or refuse to renew a policy issued by the Plan except for the following reasons:

a. Facts as confirmed by inspection or investigation that would have been grounds for nonacceptance of the risk by the Plan had they been known to the Plan at the time of acceptance.

b. Changes in the physical condition of the property or other changed conditions as confirmed by inspection or investigation that make the risk uninsurable pursuant to paragraph 20.54(1)*"i."*

c. Nonpayment of premiums.

d. At least 65 percent of the rental units in the building are unoccupied, and the insured has not received prior approval from the Plan of a rehabilitation program that necessitates a high degree of unoccupancy.

e. Unrepaired damage exists and the insured has stated that repairs will not be made, or such time has elapsed as clearly indicates that the damage will not be repaired.

f. After a loss, permanent repairs have not been commenced within 60 days following payment of the claim, unless there are known to be extenuating circumstances. The 60-day period starts upon acceptance of payment of the claim.

g. There is good cause to believe, based on reliable information, that the building will be burned for the purpose of collecting the insurance on the property. The removal of damaged salvageable items, such as normally permanent fixtures, from the building shall be considered under this paragraph when the insured can provide no reasonable explanation for such removal.

h. A named insured or loss payee or other person having a financial interest in the property being convicted of the crime of arson or a crime involving a purpose to defraud an insurance company. The fact that an appeal has been entered shall not negate the use of this paragraph.

i. The property has been subject to more than two losses, each loss amounting to at least $500 or 1 percent of the insurance in force, whichever is greater, in the immediately preceding 12-month period, or more than three such losses in the immediately preceding 24-month period, provided that the cause of such losses is due to the conditions that are the responsibility of the owner named insured or due to the actions of any person defined as an insured under the policy.

j. Material misrepresentation in any statement to the Plan.

k. On homeowners policies, excessive theft or liability losses.

20.54(2) The Plan shall terminate all insurance contracts in accordance with Iowa Code sections 515.125, 515.127, and 515.128.

20.54(3) At the completion of 36 months of coverage and prior to the completion of 48 months, each risk shall be reviewed for its eligibility for coverage in the voluntary market. The risk shall be submitted by the Plan to the producer of record, if any, for a search of the voluntary market. If the producer resubmits the risk to the Plan, the risk must be resubmitted with a new application and a written statement from the producer that a search of the voluntary market was performed.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.55(515,515F) Assessments.

20.55(1) Participation and assessments by and upon each insurer in the Plan for losses and expenses in connection with Plan business shall be levied and assessed by the governing committee of the Plan on the basis of participation factors determined annually, giving effect to the proportion that such insurer's weighted premiums written bears to the aggregate weighted premiums written by all insurers in the Plan.

20.55(2) De minimis assessments. Any assessment of less than $100 shall not be billed to an insurer.

20.55(3) Late payment fee. Assessments shall be due and payable when billed. If any member fails to pay an assessment within 60 days after it is due, the insurer shall pay interest from the billing date at the rate of 1.5 percent per month. In the event that an insurer fails to pay any applicable late payment fee with an assessment, the amount of such unpaid late payment fee will be included in the amount of the insurer's next assessment.

20.55(4) Credits for voluntary writings. The Plan may develop a voluntary writing credit policy, subject to approval by the commissioner. Credits may be used as offsets to member company assessments made by the Plan.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.56(515,515F) Commission.

20.56(1) Commission to the licensed producer designated by the applicant shall be 10 percent of all policy premiums. The Plan shall not license or appoint producers.

20.56(2) In the event of cancellation of a policy, or if an endorsement is issued that requires the premium to be returned to the insured, the producer shall refund proportionally to the Plan commissions on the return premium at the same rate at which such commissions were originally paid.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.57(515,515F) Public education. In cooperation with the insurance commissioner, the Plan shall undertake a continuing education program with insurers, producers and consumers about the Plan's insurance program and its availability. All insurers and producers shall cooperate fully in the continuing education program. Such continuing education program will include the publication and distribution of literature:

1. Describing the Plan and its general operation;
2. Explaining the possible cost savings of obtaining insurance in the voluntary market; and
3. Advising of the availability of rate comparison charts.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.58(515,515F) Cooperation and authority of producers.

20.58(1) Each insurer shall require its licensed producers to cooperate fully in the accomplishment of the intents and purposes of the Plan.

20.58(2) Licensed insurance producers shall not act as agents for the Plan.

20.58(3) Licensed insurance producers shall not do any of the following:

a. Bind coverage for the Plan.

b. Alter or change policies issued by the Plan.

c. Settle losses of the Plan.

d. Act on behalf of the Plan or commit the Plan to any course of action.

20.58(4) Licensed insurance producers shall assist applicants who need to apply for coverage under the Plan, and shall submit applications that meet the requirements under rule 191—20.49(515,515F). Producers shall follow the rules and procedures of the Plan.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.59(515,515F) Review by commissioner. The governing committee shall report to the commissioner the name of any insurer or producer that fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the governing committee or to pay within 30 days any assessment levied.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.60(515,515F) Indemnification. Each person serving on the governing committee or any of its subcommittees, each member of the Plan, and the manager and each officer and employee of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by that person in connection with the defense of any action, suit, or proceeding in which that person is made a party by reason of that person's being or having been a member of the governing committee or a member or manager or officer or employee of the Plan, except in relation to matters as to which that person has been judged in an action, suit, or proceeding to be liable by reason of willful misconduct in the performance of that person's duties as a member of the governing committee or as a member, manager, officer or employee of the Plan. This indemnification shall not apply to any loss, cost or expense on insurance policy claims under the Plan. Indemnification under this rule shall not be exclusive of other rights to which the member, manager, officer, or employee may be entitled as a matter of law.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement 2003 Iowa Acts, chapter 119.

191—20.61 to **20.69** Reserved.

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

191—20.70(515) Purpose. The purpose of division III is to clarify what information an insurance company regulated by the division may provide its customer in connection with a commercial real estate transaction between the customer and a lender.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.71(515) Definitions. For purposes of division III, the following definitions shall apply:

"ACORD" means the Association for Cooperative Operations Research and Development.

"Commercial real estate transaction" means a non-recourse commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan and neither the borrower nor any of its members, partners, or shareholders, nor any related person to any of the aforementioned persons, bears the economic risk of loss in the event of a payment default under the terms of the lending transaction.

"Division" means the insurance division.

"ISO" means the Insurance Services Office, Inc.
[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

191—20.72(515) Evidence of insurance.

20.72(1) Prior to the issuance of an insurance policy by an insurer, an insured who has entered into a commercial real estate transaction may request that the relevant insurer or a producer acting on behalf of the insurer provide the following items as evidence of insurance:

a. An ACORD Form 75, a successor ACORD form, an ISO binder form, or a substantially similar binder form approved by the division; and

b. An ACORD Form 28, a successor ACORD form, an ISO certificate form, or a substantially similar certificate of insurance form approved by the division.

The insurer or the producer acting on behalf of an insurer has the sole discretion to determine which division-approved binder form or certificate of insurance form the insurer or producer uses to comply with this rule.

20.72(2) An insurer or a producer acting on behalf of an insurer shall comply with a request made pursuant to this rule within 20 business days of the receipt of the request. The requirements of this rule shall not apply to an insurance producer who:

a. Is unauthorized to provide the documents described in this rule; and

b. Informs the insured of this fact within 20 business days of the receipt of the request.

20.72(3) Delivery of a binder along with a certificate of insurance requested pursuant to this rule may be accomplished by regular mail, overnight delivery, facsimile, physical delivery, electronic means, or other appropriate means.

20.72(4) Notwithstanding any language on a form provided pursuant to subrule 20.72(1) which language states that the form is for "information only," a binder together with a certificate of insurance delivered pursuant to this rule shall be valid and may be relied upon by the borrower or by the borrower's lender as evidence of insurance, including in any private civil action or administrative proceeding, until the delivery of the insurance policy to the borrower or the cancellation of the binder pursuant to Iowa Code sections 515.125 through 515.127.

20.72(5) An insurer or producer acting on behalf of an insurer that produces or delivers a binder and certificate of insurance to its customer pursuant to this rule may charge a reasonable fee for the production and delivery of the documents.

20.72(6) All insurers and all producers subject to this rule shall comply with the terms hereof within 90 days from May 9, 2012.

[**ARC 7736C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapter 515.

191—20.73 to **20.79** Reserved.

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

191—20.80(505B,515,515D,518,518A,519) Notice of cancellation, nonrenewal or termination of property and casualty insurance.

20.80(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to implement the policyholder protections of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B by clarifying the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer.

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8, "notice of cancellation, nonrenewal or termination" includes but is not limited to an insurance company's notice of cancellation, forfeiture, suspension, exclusion, nonrenewal, intention not to renew, or failure to renew.

20.80(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508, 515, 518, and 518A.

20.80(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

20.80(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 20.80(3), if an insurer receives approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice

requirements of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B.

This rule is intended to implement Iowa Code chapter 505B.

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[1] See IAB Insurance Division

CHAPTER 21
REQUIREMENTS FOR SURPLUS LINES, RISK RETENTION GROUPS AND PURCHASING GROUPS

[Prior to 10/22/86, Insurance Department[510]]

191—21.1(515E,515I) Definitions. In addition to the definitions provided in Iowa Code chapters 515E and 515I, the following definitions apply to this chapter, unless the context clearly requires otherwise:

"Division" means the Iowa insurance division, supervised by the commissioner pursuant to Iowa Code section 505.8, in the division's performance of the duties of the commissioner under Iowa Code chapters 515E and 515I.

"Division's website" means the website of the Iowa insurance division, iid.iowa.gov.

"Place" means obtaining insurance for an insured with a specific insurer.

[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.2(515I) Eligible surplus lines insurer's duties.

21.2(1) *Premium tax payment.* Where, pursuant to Iowa Code chapter 515I, coverage is placed with an eligible surplus lines insurer, but the surplus lines insurance producer fails to pay to the division the premium tax required by Iowa Code section 515I.3(2) and rule 191—21.3(515I), the eligible surplus lines insurer must pay the premium tax required by Iowa Code chapter 515I and this chapter.

21.2(2) *How premium tax quoted.* An eligible surplus lines insurer or a surplus lines producer for an eligible surplus lines insurer is authorized to quote a premium that includes tax as is required by Iowa Code chapter 515I, and thereafter no additional tax amount may be charged or collected. Premium tax may be stated in the contract of insurance as a separate component of the total premium only when the premium is not based upon rates or premiums that included a premium tax component. Any fees collected from residents of this state are considered part of the premium and thus are subject to taxation.

[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.3(515I) Surplus lines insurance producer's duties.

21.3(1) *Surplus lines insurance producer's collection of tax.* A surplus lines insurance producer who places insurance with an eligible surplus lines insurer must collect premium tax from the eligible surplus lines insurer by withholding the applicable percentage of premiums pursuant to Iowa Code section 432.1(3) and 432.1(4).

21.3(2) *Electronic reporting of premium tax.* A surplus lines insurance producer who places insurance with an eligible surplus lines insurer must file electronically the premium tax information with the division, as instructed on the division's website, on or before March 1 for policies issued during the preceding calendar year.

21.3(3) *Annual report.* On or before March 1 of each year, every surplus lines insurance producer who has placed insurance with an eligible surplus lines insurer when the policies have been issued during the preceding calendar year must file electronically with the division, or as otherwise directed by the division, a sworn report and supporting documentation, as instructed on the division's website, which may include evidence of a diligent search required pursuant to Iowa Code section 515I.3, of all such business written during the preceding calendar year, and must submit the amount to cover the taxes due on all such business. The manner of filing electronically and the content of the report and required supporting documentation are listed on the division's website. If no business was issued during the preceding calendar year, no report is required. Failure to file an annual report or pay the taxes imposed by Iowa Code chapter 515I will be deemed grounds for the revocation of a surplus lines insurance producer's license by the division, and failure to file an annual report or pay taxes within the time requirements of this rule will subject the surplus lines insurance producer to the penalties of Iowa Code section 515I.12.

[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.4(515I) Surplus lines insurance producer's duty to insured. A surplus lines insurance producer who places coverage with an eligible surplus lines insurer must deliver to the insured, within 30 days of the date the policy is issued, a notice that states the following: "This policy is issued,

pursuant to Iowa Code chapter 515I, by an eligible surplus lines insurer in Iowa and as such is not covered by the Iowa Insurance Guaranty Association." A surplus lines insurance producer may comply with this rule by verifying disclosure of this language in a clear and conspicuous position on the policy or by electronic delivery authorized by Iowa Code chapter 505B, if the method of delivery of the notice allows the division, the surplus lines insurance producer and the intended recipient to verify receipt of the specific notice.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.5(515I) Procedures for qualification and renewal as an eligible surplus lines insurer.

21.5(1) *Application and procedures for initial qualification as an eligible surplus lines insurer.*

a. Any nonadmitted insurer or domestic surplus lines insurer that wishes to qualify under Iowa Code chapter 515I as an eligible surplus lines insurer must make an application with the division in a format prescribed by the division, as instructed on the division's website.

b. The application must include:

(1) The name of an Iowa resident surplus lines insurance producer whom the insurer is designating as the person to accept inquiries and notices on behalf of the insurer.

(2) Payment of the greater of a $100 filing fee or a retaliatory fee, and an examination fee for all new applicants.

(3) Demonstrated maintenance of the capital and surplus required pursuant to Iowa Code chapter 515I.

21.5(2) *Procedures for renewal of an insurer as an eligible surplus lines insurer.* An eligible surplus lines insurer that was approved by the division as an eligible surplus lines insurer, except for an alien insurer under Iowa Code section 515I.2(8)*"b,"* must by March 1 of each year following the year of approval:

a. Be in compliance with subparagraph 21.5(1)*"b"*(3);

b. Pay the greater of a $100 renewal fee or a retaliatory fee; and

c. Submit to the division the documents and materials listed on the division's website.

21.5(3) *Periodic reporting.* An eligible surplus lines insurer, except for an alien insurer under Iowa Code section 515I.2(8)*"b,"* must submit annual and quarterly financial statements to the division as instructed on the division's website.

21.5(4) *Failure to comply with renewal procedures.* An eligible surplus lines insurer that fails to timely file an application for renewal as an eligible surplus lines insurer or fails to provide requested information shall pay a late fee of $500.

21.5(5) *Failure to timely file financial statements.* An eligible surplus lines insurer that fails to file a financial statement, as instructed on the division's website, shall pay a late fee of $500. The commissioner may give notice to an insurer that fails to timely file that the insurer is in violation of this subrule. If the insurer fails to file the required financial statements within ten days of the date of the notice, the insurer shall pay an additional late fee of $100 for each day the failure continues.

21.5(6) *Failure to comply with this rule.* An eligible surplus lines insurer's authority to transact new business in this state shall immediately cease until the insurer has fully complied with this rule, including paying all applicable late fees.

21.5(7) *Suspension.* The commissioner may order the suspension of an eligible surplus lines insurer's authority to transact the business of insurance within the state, after notice and hearing pursuant to Iowa Code chapter 17A, if the eligible surplus lines insurer fails to fully comply with this rule within 90 days, including paying all applicable late fees.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.6(515E) Procedures for qualification as a risk retention group.

21.6(1) Any insurer that wishes to register under Iowa Code chapter 515E as a risk retention group must file with the division an application that contains information required by Iowa Code section 515E.4, which also is listed on the division's website.

21.6(2) The risk retention group must annually provide information requested by the division for determination of continued registration.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.7(515E) Risk retention groups. A risk retention group may utilize its producers to report and pay premium taxes or may pay the taxes directly. If producers are utilized, the producers must file the premium tax information electronically with the division through the division's website on or before March 1 for policies issued during the preceding calendar year.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.8(515E) Procedures for registration as a purchasing group.

21.8(1) Prior to doing business in this state, a purchasing group must furnish to the division notice that includes:

a. The information set forth in Iowa Code section 515E.8, which also is listed on the division's website;

b. Designation of the commissioner for service of process, as set forth in Iowa Code section 515E.8(3); and

c. Remittance of a $100 filing fee.

21.8(2) A registered purchasing group must pay a $100 renewal fee by March 1 of each year following the year of registration. The purchasing group must provide information requested by the division for determination of continued registration.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

191—21.9(515E,515I) Failure to comply; penalties. Failure of a producer, surplus lines insurance producer, insurer, risk retention group or purchasing group to comply with this chapter or with Iowa Code chapters 515E and 515I may subject the producer, surplus lines insurance producer, insurer, risk retention group or purchasing group to penalties set forth in Iowa Code chapters 507B, 515E and 515I.
[**ARC 7737C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code chapters 515I and 515E.

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CHAPTER 25
MILITARY SALES PRACTICES

191—25.1(505) Purpose and authority.

25.1(1) The purpose of this chapter is to set forth standards to protect active duty service members of the United States armed forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

25.1(2) Nothing herein shall be construed to create or imply a private cause of action for a violation of this chapter.

25.1(3) This chapter is issued under the authority of Iowa Code section 505.27A.

25.1(4) This chapter shall apply to acts or practices committed on or after January 1, 2008.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.2(505) Scope. This chapter shall apply only to the solicitation or sale of any life insurance or annuity product by an insurer or insurance producer to a service member of the United States armed forces.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.3(505) Exemptions.

25.3(1) This chapter shall not apply to solicitations or sales involving:

a. Credit insurance;

b. Group life insurance or group annuities where in-person, face-to-face solicitation of individuals by an insurance producer does not occur or where the contract or certificate does not include a side fund;

c. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner, or when a term conversion privilege is exercised among corporate affiliates;

d. Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. §1965 et seq.;

e. Life insurance contracts offered through or by a nonprofit military association, qualifying under Section 501(c)(23) of the Internal Revenue Code (IRC), and that are not underwritten by an insurer; or

f. Contracts used to fund:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Section 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, if established or maintained by an employer;

(3) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC; or

(4) Settlements of or assumptions of liabilities associated with personal injury litigation or of any dispute or claim resolution process.

25.3(2) Nothing in this rule shall be construed to abrogate the ability of nonprofit or other organizations to educate members of the United States armed forces in accordance with Department of Defense DoD Instruction 1344.07, Personal Commercial Solicitation on DoD Installations, or successor directive.

25.3(3) For purposes of this chapter, general advertisements, direct mail and Internet marketing shall not constitute solicitation. Telephone marketing shall not constitute solicitation, provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the telephone communication. However, nothing in this rule shall be construed to exempt an insurer or insurance producer from the requirements of this chapter in any in-person, face-to-face meeting established as a result of the solicitation exemptions identified in this rule.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.4(505) Definitions. For purposes of this chapter, the following definitions shall apply.

"Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component (national guard and reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

"Department of Defense personnel" or *"DoD personnel"* means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

"Door to door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

"General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

"Insurance producer" means the same as defined in Iowa Code section 522B.1.

"Insurer" means the same as defined in Iowa Code section 522B.1.

"Known" or *"knowingly"* means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited:

1. Is a service member; or
2. Is a service member with a pay grade of E-4 or below.

"Life insurance" means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and, unless otherwise specifically excluded, includes individually issued annuities.

"Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

"MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

"Service member" means any active duty officer (commissioned and warrant) or enlisted member of the United States armed forces.

"Side fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement or other mechanism that accumulates premium or deposits with interest or by other means. The term does not include:

1. Accumulated value or cash value or secondary guarantees provided by a universal life policy;
2. Cash values provided by a whole life policy that are subject to standard nonforfeiture law for life insurance; or
3. A premium deposit fund that:

- Contains only premiums paid in advance that accumulate at interest;
- Imposes no penalty for withdrawal;
- Does not permit funding beyond future required premiums;
- Is not marketed or intended as an investment; and
- Does not carry a commission, either paid or calculated.

"Specific appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.

"United States armed forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.5(505) Practices declared false, misleading, deceptive or unfair on a military installation.

25.5(1) The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

a. Knowingly soliciting the purchase of any life insurance product door to door or without first establishing a specific appointment for each meeting with the prospective purchaser.

b. Soliciting service members in a group or mass audience or in a captive audience where attendance is not voluntary.

c. Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

d. Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

e. Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

f. Posting unauthorized bulletins, notices or advertisements.

g. Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit DD Form 2885.

h. Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States armed forces without first obtaining for the insurer's files a completed copy of any required form that confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the United States armed forces.

25.5(2) The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

a. Using DoD personnel, directly or indirectly, as representatives or agents in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

b. Using an insurance producer to participate in any United States armed forces-sponsored education or orientation program.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.6(505) Practices declared false, misleading, deceptive or unfair regardless of location.

25.6(1) The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

a. Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States armed forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's MyPay account or other similar Internet or electronic medium for such purposes. This subrule does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

b. Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this rule, a formal banking relationship is established when the depository institution:

(1) Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. §4301 et seq., and the regulations promulgated thereunder; and

(2) Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

c. Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service

member's Leave and Earnings Statement or equivalent or successor form as "savings" or "checking" and where the service member has no formal banking relationship as defined in paragraph 25.6(1)*"b."*

d. Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

e. Using DoD personnel, directly or indirectly, as representatives or agents in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

f. Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

g. Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for the service member's attendance at any event where an application for life insurance is solicited.

h. Advising a service member with a pay grade of E-4 or below to change the service member's income tax withholding or state of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

25.6(2) The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

a. Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. government, the United States armed forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor."

Nothing in this subrule shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science in Financial Services (MSFS), or Masters of Science Financial Planning (MS).

b. Soliciting the purchase of any life insurance product through the use of or in conjunction with any third-party organization that promotes the welfare of or assists a member of the United States armed forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. government or the United States armed forces.

25.6(3) The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

a. Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

b. Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product costs nothing or is free.

25.6(4) The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

a. Making any representation regarding the availability, suitability, amount or cost of or exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI that is false, misleading or deceptive.

b. Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers that is false, misleading or deceptive.

c. Suggesting, recommending or encouraging a service member to cancel or terminate the service member's SGLI policy, or issuing a life insurance policy that replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the United States armed forces.

25.6(5) The following acts or practices by an insurer or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

a. Deploying, using or contracting for any lead-generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

b. Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.

c. Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.

d. Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act, Pub. L. No. 109-290, p.16.

e. Excluding individually issued annuities, when an in-person, face-to-face sale is conducted with an individual known to be a service member, failing at the time the application is taken to provide the applicant:

(1) An explanation of any free-look period with instructions on how to cancel if a policy is issued; and

(2) Either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance and the death benefit applied for and its expected first-year cost. A basic illustration that meets the requirements of 191—Chapter 15 and Iowa Code chapter 507B shall be deemed sufficient to meet this requirement for a written disclosure.

25.6(6) The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

a. Excluding individually issued annuities, recommending the purchase of any life insurance product that includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

b. Offering for sale or selling a life insurance product that includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(1) "Insurable needs" means the risks associated with premature death, taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and survivors or dependents.

(2) "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE health care benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

c. Excluding individually issued annuities, offering for sale or selling any life insurance contract that includes a side fund:

(1) Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(2) Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender

values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one to ten and for every fifth policy year thereafter ending at the insured's age 100, the policy's maturity date or the policy's final expiration date; and

(3) That by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premium due.

d. Excluding individually issued annuities, offering for sale or selling any life insurance contract that after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

e. Selling to an individual known to be a service member any life insurance product that excludes coverage if the insured's death is related to war, declared or undeclared, or to any act related to military service except for an accidental death coverage, e.g., double indemnity, which may be excluded.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.7(505) Reporting requirements. No insurer may participate in any military sales unless that insurer has implemented a system to report to the Iowa insurance commissioner in a manner prescribed by the commissioner any military sales disciplinary actions about which the insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the action, and unless the insurer also has reported such action to the commissioner. Failure to comply with this rule shall be a violation of this chapter and shall subject the insurer to penalties set forth in rule 191—25.8(505).

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.8(505) Violation and penalties.

25.8(1) Any insurance producer or insurer found after hearing to have violated a provision of this chapter shall be deemed to have committed an unfair trade practice under Iowa Code chapter 507B and shall be subject to the penalties set forth in Iowa Code chapters 505 and 507B.

25.8(2) Any insurance producer or insurer found after hearing to have violated a provision of this chapter will be reported by the commissioner pursuant to, and may be subject to, the penalties set forth in Section 10(d) of the Military Personnel Financial Services Protection Act, Pub. L. No. 109-290 (2006).

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

191—25.9(505) Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these rules that can be given effect without the invalid provisions or application. To this end, all provisions of these rules are declared to be severable.

[**ARC 7738C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code section 505.27A.

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CHAPTER 60
WORKERS' COMPENSATION INSURANCE RATE FILING PROCEDURES

191—60.1(515A) Purpose.

60.1(1) The purpose of this chapter is to set forth filing procedures and parameters for rates as required by Iowa Code chapter 515A.

60.1(2) Nothing herein shall be construed to create or imply a private cause of action for a violation of this chapter.

[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.2(515A) Definitions, scope, authority.

60.2(1) The definitions in Iowa Code section 515A.2 are incorporated into this chapter by this reference. In addition, the following definitions shall apply:

"Division" means the Iowa insurance division.

"SERFF" means the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing.

60.2(2) This chapter shall apply only to workers' compensation liability insurance.

60.2(3) This chapter is issued under the authority of Iowa Code section 505.8 and chapter 515A.

[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.3(515A) General filing requirements.

60.3(1) Insurers required to file rates with the division shall submit required rate filings and any fees required for the filings electronically using SERFF. Insurers must comply with the division's requirements, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set out on the SERFF website at serff.com.

60.3(2) No rate filing shall include any adjustment designed to recover underwriting or operating losses incurred out of state. Upon request by the division, insurers doing business in Iowa shall segregate in their rate filings data from any state identified by the division, and the filings shall include a certification that no portion of any rate increase is designed to recover underwriting or operating losses incurred in another state.

[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.4(515A) Rate or manual rule filing.

60.4(1) Every insurer, either on its own or via a licensed rating organization, shall file with the division, pursuant to provisions of Iowa Code chapter 515A, every manual, minimum, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing that it proposes to use.

Every insurer shall adhere to the filings made on its behalf by a rating organization except that any such insurer may file a deviation from the class rates, schedules, rating plans, or rules, or a combination thereof, at any time during the year and, once approved, the deviation need only be refiled to propose changes to any filing.

60.4(2) An insurer may file for approval by the division a uniform percentage rate deviation to be applied to the class rates of the rating organization's filing.

a. A rate deviation from the approved class rates of a rating organization shall not exceed 15 percent nor shall it cause the rate charged a policyholder to exceed the approved assigned risk rates but must state whether or not the proposed deviation is to be applied to minimum premiums.

b. In the event that an insurer has an existing approved filing for which the deviation results in rates above those approved for the assigned risk, the insurer must use the same deviation as approved for the assigned risk effective the same date as the approval of the assigned risk rates. A filing must be made confirming use of the new deviation on that date.

60.4(3) Schedule rating may be used by any company, regardless of whether that company has an approved deviation. The maximum modification allowed for schedule rating is 15 percent for individual policies.
[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.5(515A) Violation and penalties. Any insurer found after hearing to have violated a provision of this chapter shall be deemed to have committed an unfair trade practice under Iowa Code chapter 507B and shall be subject to the penalties set forth in Iowa Code chapter 507B.
[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.6(515A) Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these rules that can be given effect without the invalid provisions or application. To this end, all provisions of these rules are declared to be severable.
[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

191—60.7(515A) Effective date. These rules are effective as of April 24, 2024, and apply to acts or practices committed on or after January 1, 2009.
[**ARC 7740C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code section 515A.7.

[Filed 8/20/08, Notice 7/2/08—published 9/10/08, effective 1/1/09]
[Filed ARC 7740C (Notice ARC 7355C, IAB 1/24/24), IAB 3/20/24, effective 4/24/24]

CHAPTER 90
FINANCIAL AND HEALTH INFORMATION REGULATION

191—90.1(505) Purpose and scope.

90.1(1) This chapter governs the treatment of nonpublic personal financial information and nonpublic personal health information about individuals by all licensees of the insurance division.

90.1(2) This chapter also applies to nonpublic personal financial information and nonpublic personal health information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This chapter does not apply to information about individuals or companies that obtain products or services for business, commercial or agricultural purposes.

90.1(3) A licensee domiciled in this state that is in compliance with this chapter shall be deemed to be in compliance with Title V of P.L. 106-102 in a state that has not enacted laws or regulations that meet the requirements of Title V.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.2(505) Definitions. For the purpose of these rules, the following definitions shall apply:

"Affiliate" means any company that controls, is controlled by or is under common control with another company.

"Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

"Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying article assigned to the individual, irrespective of the source of the underlying information.

"Commissioner" means the insurance commissioner.

"Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

"Consumer" means an individual, or that individual's legal representative, who seeks to obtain, obtains or has obtained from a licensee an insurance product or service that is to be used primarily for personal, family or household purposes and about whom the licensee has nonpublic personal information. "Consumer" includes any of the following:

1. An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.
2. An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.
3. An individual is a licensee's consumer if:

- The individual is a beneficiary of a life insurance policy underwritten by the licensee;
- The individual is a claimant under an insurance policy issued by the licensee;
- The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or
- The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and
- The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under rules 191—90.12(505), 191—90.13(505) and 191—90.14(505) of this chapter.

An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

An individual is not the consumer of the licensee provided that the licensee provides the initial, annual and revised notices required under rules 191—90.3(505), 191—90.4(505), and 191—90.7(505) to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, workers' compensation plan participant, or further, provided that the licensee does not disclose to a nonaffiliated

third party nonpublic personal financial information about such an individual other than as permitted under rules 191—90.12(505), 191—90.13(505), and 191—90.14(505) and solely due to any of the following:

a. The consumer is a participant in or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary,

b. The consumer is covered under a group or blanket insurance policy or group annuity contract issued by the licensee, or

c. The consumer is a beneficiary in a workers' compensation plan.

However, an individual described in *"a"* through *"c"* is a consumer of a licensee if the licensee does not meet all the above conditions. In no event shall an individual solely by virtue of the status described in *"a"* through *"c"* above be deemed a customer for purposes of this chapter.

An individual is not a licensee's consumer solely because the individual is a beneficiary of a trust for which the licensee is a trustee or because the individual has designated the licensee as trustee for a trust.

"Consumer reporting agency" means "consumer reporting agency" as defined in Section 603(f) of the federal Fair Credit Reporting Act.

"Control" means any of the following:

1. Ownership, control or power to vote 25 percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

2. Control in any manner over the election of a majority of the directors, trustees or general partners or individuals exercising similar functions of the company; or

3. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

"Customer" means a consumer who has a customer relationship with a licensee.

"Customer information" means nonpublic personal information about a customer, whether the information is in paper, electronic or other form, that is maintained by or on behalf of the licensee.

"Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect or dispose of customer information.

"Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides to the consumer one or more insurance products or services that are to be used primarily for personal, family or household purposes.

A consumer has a continuing relationship with a licensee if the consumer is a current policyholder of an insurance product issued by or through the licensee or if the consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

A consumer does not have a continuing relationship with a licensee under the following examples:

1. The consumer applies for insurance but does not purchase the insurance;

2. The licensee sells the consumer airline travel insurance in an isolated transaction;

3. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

4. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

5. The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

6. The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

7. The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

8. For the purposes of these rules, the individual's last-known address according to the licensee's record is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

"Designed to call attention" means a licensee designs its notice to call attention to the nature and significance of the information in a notice if the licensee does the following:

1. Uses a plain-language heading to call attention to the notice;
2. Uses a typeface and type size that are easy to read;
3. Provides wide margins and ample line spacing;
4. Uses boldface or italics for key words; and
5. Uses a form that combines the licensee's notice with other information and uses distinctive type size, style, and graphic devices, such as shading or sidebars.

"Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to the financial activities described in Section 4(k) of the Bank Holding Company Act of 1956. "Financial institution" does not include the following:

1. Any person or entity with respect to any financial activity that is subject to the jurisdiction of the commodity futures trading commissioner under the Commodity Exchange Act.
2. The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971.
3. Institutions chartered by Congress specifically to engage in securitizations, secondary market sales including sales of servicing rights, or similar transactions related to a transaction of a consumer as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

"Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956. Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

"Health care" means preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that relates to the physical, mental or behavioral condition of an individual or affects the structure or function of the human body or any part of the human body including the banking of blood, sperm, organs or any other tissues. "Health care" also means prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

"Health care provider" means a physician or health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

"Health information" means any information or data except age, gender or nonmedical identifying information, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to the following:

1. The past, present or future physical, mental or behavioral health or condition of an individual;
2. The provision of health care to an individual; or
3. Payment for the provision of health care to an individual.

"Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of Iowa. "Insurance service" includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

"Licensee" means all licensed carriers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of the state or by the department of health and human services. "Licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker but only in regard to the excess lines placements pursuant to state rules.

"Nonaffiliated third party" means any person except a licensee's affiliate or a person employed jointly by a licensee and any company that is not a licensee's affiliate. "Nonaffiliated third party" includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) of the federal Bank Holding Company Act or insurance

company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act.

"Nonpublic personal health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Nonpublic personal information" or *"nonpublic personal financial information"* means personally identifiable financial information and any list, description or other groupings of consumers and publicly available information pertaining to them that is derived using any personally identifiable financial information that is not publicly available.

"Nonpublic personal financial information" does not include health information, publicly available information, except as included on a list as described above or any list or description pertaining to consumers that is derived without using any personally identifiable financial information that is not publicly available.

"Opt out" means a direction by the consumer that the licensee not disclose nonpublic personal financial information about the consumer to a nonaffiliated third party other than as permitted by rules 191—90.12(505), 191—90.13(505), and 191—90.14(505).

"Personally identifiable financial information" means any information a consumer provides to a licensee to obtain an insurance product or service from the licensee, information about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer, or information the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

Examples of "personally identifiable financial information" include:

1. Information a consumer provides to a licensee on an application to obtain an insurance product or service;
2. Account balance information and payment history;
3. The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;
4. Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;
5. Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;
6. Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and
7. Information from a consumer report.

"Personally identifiable financial information" does not include health information, a list of names and addresses of customers of an entity that is not a financial institution and information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, and addresses.

"Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records; widely distributed media sources; or disclosures to the general public that are required to be made by federal, state or local law.

A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine that the information is the type that is available to the general public and whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

Examples of "publicly available information" include:

1. Publicly available information in government records, which includes information in government real estate records and security interest filings.
2. Publicly available information from widely distributed media, which includes information from a telephone book, a television or radio program, a newspaper or a website that is available to the general

public on an unrestricted basis. A website is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

3. A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

"Reasonably understandable" means the licensee's notice is reasonably understandable if it:

1. Uses clear, concise sentences, paragraphs, and sections;
2. Uses short explanatory sentences or bullet lists whenever possible;
3. Uses definite, concrete, plain language and active voice whenever possible;
4. Avoids multiple negatives;
5. Avoids legal or highly technical business terminology whenever possible; and
6. Avoids explanations that are imprecise and readily subject to different interpretations.

"Service provider" means a person who maintains, processes or otherwise is permitted access to customer information through the person's provision of services directly to the licensee.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

DIVISION I
RULES FOR FINANCIAL INFORMATION

191—90.3(505) Initial privacy notice to consumers required.

90.3(1) A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to the following persons and at the following times:

a. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subrule 90.3(5); and

b. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by rules 191—90.13(505) and 191—90.14(505).

90.3(2) A licensee is not required to provide an initial notice to a consumer under subrule 90.3(1) if:

a. The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party other than as authorized by rules 191—90.13(505) and 191—90.14(505) and the licensee does not have a customer relationship with the consumer; or

b. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions; or

c. The licensee has a customer relationship with the consumer and the consumer consents to the licensee's searching for insurance coverage to replace existing coverage or the licensee is selling the agency expiration lists or the agency contract is canceled and the licensee is required to move the existing coverage to a new carrier.

90.3(3) A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship. A licensee establishes a customer relationship when the consumer does either of the following:

a. Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer or, in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

b. Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

90.3(4) When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of subrule 90.3(1) as follows:

a. The licensee provides a revised policy notice under rule 191—90.7(505) that covers the customer's new insurance product or service; or

b. If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subrule 90.3(1).

90.3(5) A licensee may provide the initial notice required by paragraph 90.3(1)*"a"* within a reasonable time after the licensee establishes a customer relationship if:

a. Establishing the customer relationship is not at the customer's election; or

b. Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

Examples of notice within a reasonable time are as follows:

- The establishment of the customer relationship is not at the customer's election. Establishing the customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.
- There is substantial delay in the customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.
- Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a website.

90.3(6) When a licensee is required by this rule to deliver an initial privacy notice, the licensee shall deliver it according to rule 191—90.8(505). If the licensee uses a short-form initial notice for noncustomers according to subrule 90.5(6), the licensee may deliver its privacy notice according to subrule 90.5(6).

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.4(505) Annual privacy notice to customers required.

90.4(1) A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. "Annually" means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

A licensee provides a notice annually if it defines the 12-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

90.4(2) A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

a. A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

b. A licensee no longer has a continuing relationship with an individual if the individual's policy lapsed, expired or is otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of 12 consecutive months, other than to provide annual notices, material required by law or regulation, or promotional materials.

c. For purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

d. A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

90.4(3) When a licensee is required by this rule to deliver an annual privacy notice, the licensee shall deliver it according to rule 191—90.8(505).

90.4(4) A licensee is not required to provide an annual privacy notice if both of the following are true: the licensee has not changed the privacy policies and practices that the licensee disclosed to the consumer in the privacy notice that the licensee most recently delivered to the consumer in accordance with rule 191—90.3(505) or this rule; and the licensee does not disclose any nonpublic personal information about the consumer to any nonaffiliated third party except as authorized by rules 191—90.12(505), 191—90.13(505) and 191—90.14(505). If a licensee at any time fails to comply with the criteria of this subrule, the licensee shall immediately provide to the consumer the annual privacy notice required under this chapter.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.5(505) Information to be included in privacy notices.

90.5(1) The initial annual and revised privacy notices that a licensee provides under rules 191—90.3(505), 191—90.4(505) and 191—90.7(505) shall include each of the following items of information in addition to any other information the licensee wants to provide and that apply to the licensee and to the consumers to whom the licensee sends its privacy notice:

a. The categories of nonpublic personal financial information that the licensee collects;

b. The categories of nonpublic personal financial information that the licensee discloses;

c. The categories of affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information, other than those parties to which the licensee discloses information under rules 191—90.13(505) and 191—90.14(505);

d. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to which the licensee discloses information under rules 191—90.13(505) and 191—90.14(505);

e. A separate description of the categories of information the licensee discloses and the categories of third parties with which the licensee has contracted if a licensee discloses nonpublic personal financial information to a nonaffiliated third party under rule 191—90.12(505) and no other exception in rules 191—90.13(505) and 191—90.14(505) applies to that disclosure;

f. An explanation of the consumer's right under subrule 90.9(1) to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

g. Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act;

h. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information; and

i. Any disclosure that the licensee makes under subrule 90.5(2).

90.5(2) If a licensee discloses nonpublic personal financial information as authorized under rules 191—90.13(505) and 191—90.14(505), the licensee is not required to list those exceptions in the initial or annual privacy notices required by rules 191—90.3(505) and 191—90.4(505). When describing the categories of parties to which disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable and permitted by law.

90.5(3) Examples of nonpublic personal financial information are as follows:

a. Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(1) Information from the consumer;

(2) Information about the consumer's transactions with the licensee or its affiliates;

(3) Information about the consumer's transactions with nonaffiliated third parties; and

(4) Information from a consumer reporting agency.

b. Categories of nonpublic personal financial information a licensee discloses. A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in paragraph 90.5(3)*"a,"* as applicable, and provides examples to illustrate the types of information in each category. These might include the following:

(1) Information from the consumer, including application information, such as assets and income and identifying information such as name, address and social security number;

(2) Transaction information, such as information about balances, payment history and parties to the transaction; and

(3) Information from consumer reports, such as a consumer's creditworthiness and credit history.

A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

c. Categories of affiliates and nonaffiliated third parties to which the licensee discloses. A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which the affiliate and nonaffiliated third parties engage.

(1) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term "financial products or services" if it includes appropriate examples of significant lines of business, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(2) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

90.5(4) If a licensee discloses nonpublic personal financial information under the exception in rule 191—90.12(505) to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of paragraph 90.5(1)*"e"* if it does the following:

a. Lists the categories of nonpublic personal financial information it discloses using the same categories and examples the licensee used to meet the requirements of paragraph 90.5(1)*"b"* as applicable; and

b. States whether the third party is a service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution or a financial institution with which the licensee has a joint marketing agreement.

90.5(5) If a licensee does not disclose and does not wish to reserve the right to disclose nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under rules 191—90.13(505) and 191—90.14(505), the licensee may simply state that fact, in addition to the information it shall provide under paragraphs 90.5(1)*"a," "h,"* and *"i"* and subrule 90.5(2).

90.5(6) A licensee shall describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

a. Describes in general terms who is authorized to have access to the information; and

b. States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

90.5(7) A licensee may satisfy the initial notice requirements in paragraph 90.3(1)*"b"* and subrule 90.6(4) for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt-out notice as required in rule 191—90.6(505).

a. The short-form initial notice shall be clear and conspicuous, state that the licensee's privacy notice is available upon request and explain a reasonable means by which the consumer may obtain that notice.

b. The licensee shall deliver its short-form initial notice according to rule 191—90.8(505). The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to rule 191—90.8(505).

c. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee provides a toll-free telephone number that the consumer may call to request the notice or, for a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

90.5(8) The licensee's notice may include categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future but does not currently disclose and categories of affiliates or nonaffiliated third parties to which the licensee reserves the right in the future to disclose, but to which the licensee does not currently disclose, nonpublic personal financial information. Sample clauses are found in Appendix A.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.6(505) Form of opt-out notice to consumers and opt-out methods.

90.6(1) A licensee required to provide an opt-out notice under subrule 90.9(1) shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that rule. The notice shall state the following:

a. The licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

b. The consumer has the right to opt out of that disclosure; and

c. A reasonable means by which the consumer may exercise the opt-out right.

90.6(2) Examples of the opt-out notice include the following:

a. Adequate opt-out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee does the following:

(1) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in paragraphs 90.5(1)*"b"* and *"c,"* and states that the consumer can opt out of the disclosure of that information; and

(2) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt-out direction applies.

b. Reasonable opt out. A licensee provides a reasonable means to exercise an opt-out right if it provides the following:

(1) Designates check-off boxes in a prominent position on the relevant forms with the opt-out notice;

(2) Includes a reply form together with the opt-out notice;

(3) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's website, if the consumer agrees to the electronic delivery of information; or

(4) Provides a toll-free telephone number that consumers may call to opt out.

c. Unreasonable opt out. A licensee does not provide a reasonable means of opting out in the following circumstances:

(1) The only means of opting out is for the consumer to write the consumer's own letter to exercise that opt-out right; or

(2) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

d. Specific opt out. A licensee may require each consumer to opt out through a specific means as long as that means is reasonable for that consumer.

90.6(3) A licensee may provide the opt-out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with rule 191—90.3(505).

90.6(4) If a licensee provides the opt-out notice later than required for the initial notice in accordance with rule 191—90.3(505), the licensee shall also include in writing or, if the consumer agrees, electronically a copy of the initial notice with the opt-out notice.

90.6(5) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt-out notice. The licensee's opt-out notice shall explain how the licensee will treat an opt-out direction by a joint consumer.

a. Any of the joint consumers may exercise the right to opt out. The licensee may do either of the following:

(1) Treat an opt-out direction by a joint consumer as applying to all of the associated joint consumers; or

(2) Permit each joint consumer to opt out separately.

b. The licensee shall permit one of the joint consumers to opt out on behalf of all the joint consumers if a licensee permits each joint consumer to opt out separately.

c. A licensee may not require all joint consumers to opt out before it implements any opt-out direction.

d. Examples of opt-out notice requirements for joint consumers. If John and Mary are both names of policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt-out notice which of the following opt-out policies the licensee will follow:

(1) Send a single opt-out notice to John's address, but the licensee shall accept an opt-out direction from either John or Mary.

(2) Treat an opt-out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt-out direction.

(3) Permit John and Mary to make different opt-out directions. If the licensee does so, it shall provide for the following:

1. Permit John and Mary to opt out for each other;

2. Permit both of them to notify the licensee in a single response such as on a form or through a telephone call if both opt out; and

3. Allow the licensee to disclose nonpublic personal financial information about one of them such as Mary but not about John if John opts out and Mary does not and not about John and Mary jointly.

90.6(6) A licensee shall comply with a consumer's opt-out direction as soon as reasonably practicable after the licensee receives it.

90.6(7) A consumer may exercise the right to opt out at any time.

90.6(8) A consumer's direction to opt out under this rule is effective until the consumer revokes it in writing or electronically, if the consumer agrees to revoke electronically.

90.6(9) When a customer relationship terminates, the customer's opt-out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt-out direction that applied to the former relationship does not apply to the new relationship.

90.6(10) When a licensee is required to deliver an opt-out notice by this rule, the licensee shall deliver it according to rule 191—90.8(505).
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.7(505) Revised privacy notices.

90.7(1) Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under rule 191—90.3(505) unless the following occur:

a. The licensee has provided to the consumer a clear and conspicuous revised privacy notice that accurately describes its policies and practices;

b. The licensee has provided to the consumer a new opt-out notice;

c. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

d. The consumer does not opt out.

Except as permitted by rules 191—90.12(505), 191—90.13(505), and 191—90.14(505), a licensee shall provide a revised notice before the licensee does any of the following:

- Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;
- Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or
- Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt-out right regarding that disclosure.

90.7(2) A revised privacy notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

90.7(3) When a licensee is required to deliver a revised privacy notice by this rule, the licensee shall deliver it according to rule 191—90.8(505).
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.8(505) Delivery of notice.

90.8(1) A licensee shall provide any notices that these rules require so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

a. Examples of reasonable expectation of actual notice by a licensee are as follows:

(1) Hand delivery of a printed copy of the notice to the consumer;

(2) Mailing a printed copy of the notice to the last-known address of the consumer separately or in a policy, billing or other written communication;

(3) For a consumer who conducts transactions electronically, posting the notice on the website and requiring the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(4) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posting the notice and requiring the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

b. Examples of unreasonable expectation of actual notice by a licensee are as follows:

(1) Only posting a sign in its office or generally publishing advertisements of its privacy policies and practices; or

(2) Sending the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

90.8(2) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if one of the following occurs:

a. The customer uses the licensee's website to access insurance products and services electronically and agrees to receive notices at the website and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the website; or

b. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

90.8(3) A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone.

90.8(4) For customers only, a licensee shall provide the initial notice required by paragraph 90.3(1)*"a,"* the annual notice required by subrule 90.4(1) and the revised notice required by rule 191—90.7(505) so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

A licensee provides a privacy notice to the customer so that the customer can retain the notice or obtain the notice later if the licensee does any of the following:

a. Hand delivers a printed copy of the notice to the customer;

b. Mails a printed copy of the notice to the last-known address of the customer; or

c. Makes its current privacy notice available on a website or a link to another website for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the website.

90.8(5) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution.

90.8(6) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of subrules 90.3(1), 90.4(1) and 90.7(1), respectively, by providing one notice to those consumers jointly.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.9(505) Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties.

90.9(1) A licensee may not directly or through any affiliate disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party except as otherwise authorized in these rules unless the following occur:

a. The licensee has provided to the consumer an initial notice as required under rule 191—90.3(505);

b. The licensee has provided to the consumer an opt-out notice as required in rule 191—90.6(505);

c. The licensee has given the consumer a reasonable opportunity to opt out of the disclosure before the licensee discloses the information to the nonaffiliated third party; and

d. The consumer does not opt out.

90.9(2) A licensee provides a consumer with a reasonable opportunity to opt out under the following methods:

a. The licensee mails the notices required in subrule 90.9(1) to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within 30 days from the date the licensee mailed the notices.

b. A customer opens an online account with a licensee and agrees to receive the notices required in subrule 90.9(1) electronically, and the licensee allows the customer to opt out by any reasonable means within 30 days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

c. For an isolated transaction such as providing the customer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notice required in subrule 90.9(1) at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

90.9(3) A licensee shall comply with this rule regardless of whether the licensee and the consumer have established a customer relationship.

90.9(4) Unless a licensee complies with this rule, the licensee may not directly or through any affiliate disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

90.9(5) A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.10(505) Limits on redisclosure and reuse of nonpublic personal financial information.

90.10(1) In the event a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception to rules 191—90.13(505) and 191—90.14(505), the licensee's disclosure and use of that information is limited as follows:

a. The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

b. The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

c. The licensee may disclose and use the information pursuant to an exception in rule 191—90.13(505) or 191—90.14(505) in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

90.10(2) In the event a licensee received nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in rules 191—90.13(505) and 191—90.14(505), the licensee may disclose the information only as follows:

a. To the affiliates of the financial institution from which the licensee received the information;

b. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

c. To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

In the event a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in rule 191—90.13(505) or 191—90.14(505), the licensee may use that list for its own purposes and the licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party.

The licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list as limited by the opt-out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in rule 191—90.13(505) or 191—90.14(505), such as to the licensee's attorneys or accountants.

90.10(3) In the event a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in rules 191—90.13(505) and 191—90.14(505), the third party may disclose and use that information only as follows:

a. The third party may disclose the information to the licensee's affiliates;

b. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

c. The third party may disclose and use the information pursuant to an exception in rules 191—90.13(505) and 191—90.14(505) in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

90.10(4) In the event a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in rules 191—90.13(505) and 191—90.14(505), the third party may disclose the information only to the following:

a. The licensee's affiliates;

b. The third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

c. Any other person, if the disclosure would be lawful if the licensee made it directly to that person.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.11(505) Limits on sharing account number information for marketing purposes.

90.11(1) A licensee shall not directly or through an affiliate disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct-mail marketing or marketing through electronic mail to the consumer.

90.11(2) The above subrule does not apply if a licensee discloses a policy number or similar form of access number or access code to any of the following:

a. A licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

b. A licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

c. A participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

A policy number or similar form of access number or access code does not include a number or code in encrypted form as long as the licensee does not provide the recipient with a means to decode the number or code.

For purposes of this subrule, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.12(505) Exception to opt-out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing.

90.12(1) The opt-out requirements in rules 191—90.6(505) and 191—90.9(505) do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions for the licensee on the licensee's behalf, if the licensee does the following:

a. Provides the initial notice in accordance with rule 191—90.3(505); and

b. Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in rules 191—90.13(505) and 191—90.14(505) in the ordinary course of business to carry out those purposes.

For example, if a licensee discloses nonpublic personal financial information under this rule to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of paragraph *"b"* of this subrule if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in rules 191—90.13(505) and 191—90.14(505) in the ordinary course of business to carry out that joint marketing.

90.12(2) The services a nonaffiliated third party performs for a licensee under subrule 90.12(1) may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

90.12(3) For purposes of this rule, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.13(505) Exceptions to notice and opt-out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions.

90.13(1) The requirements for initial notice in paragraph 90.3(1)*"b,"* for the opt out in rules 191—90.6(505) and 191—90.9(505), and for service providers and joint marketing in rule 191—90.12(505) do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with the following:

a. Servicing or processing an insurance product or service that a consumer requests or authorizes;

b. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private-label credit card program or other extension of credit on behalf of such entity;

c. A proposed or actual securitization, secondary market sale including sales of servicing rights, or similar transaction related to a transaction of the consumer; or

d. Reinsurance or stop loss or excess loss insurance.

90.13(2) For purposes of this rule, "necessary to effect, administer or enforce a transaction" means that the disclosure is as follows:

a. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

b. Required, or is a usual, appropriate or acceptable method, for the following transactions:

(1) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(2) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(3) To provide a confirmation, statement or other record of the transaction or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(4) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(5) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits including utilization review activities, participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(6) To disclose in connection with the following:

1. The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

2. The transfer of receivables, accounts or interests therein; or

3. The audit of debit, credit or other payment information.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.14(505) Other exceptions to notice and opt-out requirements for disclosure of nonpublic personal financial information.

90.14(1) The requirements for initial notice to consumers in paragraph 90.3(1)*"b,"* for the opt out in rules 191—90.6(505) and 191—90.9(505), and for service providers and joint marketing in rule 191—90.12(505) do not apply when a licensee discloses nonpublic personal financial information as follows:

a. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

b. To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

c. To protect against or prevent actual or potential fraud or unauthorized transactions;

d. For required institutional risk control or for resolving consumer disputes or inquiries;

e. To persons holding a legal or beneficial interest relating to the consumer;

f. To persons acting in a fiduciary or representative capacity on behalf of the consumer;

g. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

h. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978, to law enforcement agencies including the Federal Reserve Board; Office of the Comptroller of the Currency; Federal Deposit Insurance Corporation; Office of Thrift Supervision; National Credit Union Administration; the Securities and Exchange Commission; the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II, and 12 U.S.C. Chapter 21, a state insurance authority, and the Federal Trade Commission, self-regulatory organizations or for an investigation on a matter related to public safety;

i. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act;

j. From a consumer report reported by a consumer reporting agency;

k. In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business unit;

l. To comply with federal, state, or local laws, rules and other applicable legal requirements;

m. To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

n. To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law;

o. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

90.14(2) A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal financial information as permitted under subrule 90.6(7).
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.15(505) Notice through a website. If a licensee provides a notice on a website, the licensee shall comply with the above requirements if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the website such as text, graphics, hyperlinks or sound do not distract attention from the notice. In addition, the licensee shall either place the notice on a screen that consumers frequently access, such as a page on which transactions are conducted, or place a link on a screen that consumers frequently access that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.16(505) Licensee exception to notice requirement.

90.16(1) A licensee is not subject to the notice and opt-out requirements for nonpublic personal financial information if:

a. The licensee is an employee, agent or other representative of another licensee; and

b. The other licensee otherwise complies with, and provides the notices required by, the provisions of the rules and the licensee does not disclose any nonpublic personal financial information to any person other than the other licensee or its affiliates in a manner permitted by these rules.

90.16(2) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt-out requirements for nonpublic personal financial information in these rules provided the following:

a. The broker or insurer does not disclose nonpublic personal financial information of a consumer or a customer to nonaffiliated third parties for any purpose including joint servicing or marketing under rule 191—90.12(505) except as permitted by rule 191—90.13(505) or 191—90.14(505); and

b. The broker or insurer delivers to the consumer at the time a customer relationship is established a notice on which the following is printed in 16-point type:

PRIVACY NOTICE

NEITHER THE U.S. BROKER THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

DIVISION II
RULES FOR HEALTH INFORMATION

191—90.17(505) Disclosure of nonpublic personal health information.

90.17(1) A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

90.17(2) Nothing in this rule shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee or the licensee's insurance affiliate for the performance of the following insurance functions by or on behalf of the licensee: claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; rate-making and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the commissioner to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.18(505) Authorizations.

90.18(1) A valid authorization to disclose nonpublic personal health information pursuant to the health information rules as required under subrule 90.17(1) shall be in written or electronic form and shall contain all of the following:

a. The identity of the consumer or customer who is the subject of the nonpublic personal health information;

b. A general description of the types of nonpublic personal health information to be disclosed;

c. General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

d. The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

e. Notice of the length of time for which the authorization is valid, the fact that the consumer or customer may revoke the authorization at any time, and the procedure for making a revocation.

90.18(2) An authorization for the purposes of these health information rules shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than 24 months.

90.18(3) A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to these health information rules at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

90.18(4) A licensee shall retain the authorization or a copy in the record of the individual who is the subject of nonpublic personal health information.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.19(505) Delivery of authorization request. A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to rule 191—90.8(505), provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to subrule 90.17(1).
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.20(505) Relationship to federal rules. Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services, if a licensee complies with all requirements of the federal rules except for their effective date provision, the licensee shall not be subject to the provisions of these health information rules.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.21(505) Relationship to state laws. Nothing in these health information rules shall preempt or supersede existing state law related to medical records, health or insurance information privacy.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.22(505) Protection of Fair Credit Reporting Act. Nothing in these rules shall be construed to modify, limit or supersede the operations of the federal Fair Credit Reporting Act, and no inference shall be drawn on the basis of the provisions of these rules regarding whether information is transaction or experience information under Section 603 of that Act.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.23(505) Nondiscrimination. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of the consumer's or customer's nonpublic personal financial information pursuant to the provisions of this chapter.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.24(505) Severability. If any rule or portion of a rule of this chapter or its applicability to any person or circumstance is held invalid by a court, the remainder of the rules or the applicability of the provision to other persons or circumstances shall not be affected.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.25(505) Penalties. An insurer or producer or licensee that violates a requirement of these rules shall be found to have committed a violation of Iowa Code section 507B.4 in addition to any other penalties provided by the laws of this state.
[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.26(505) Effective dates.

90.26(1) These rules became effective November 13, 2000. However, in order to provide sufficient time for licensees to establish policies and systems to comply with the requirements of these rules, the commissioner extends the time for compliance until July 1, 2001.

90.26(2) A licensee shall provide by July 1, 2001, an initial notice as required by rule 191—90.3(505) to consumers who are the licensee's customers on July 1, 2001. A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

90.26(3) Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of paragraph 90.12(1)*"a,"* even if the contract does not include a requirement that the third party maintain confidentiality of nonpublic personal financial information, provided that the licensee entered into the agreement on or before July 1, 2001.

90.26(4) The rules regarding health information are effective January 2, 2002, and no administrative action against noncompliance shall be taken until January 2, 2002.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.27 to **90.36** Reserved.

DIVISION III
SAFEGUARDING CUSTOMER INFORMATION

191—90.37(505) Information security program.

90.37(1) Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of the licensee's activities.

90.37(2) A licensee's information security program shall be designed to:

a. Ensure the security and confidentiality of customer information;

b. Protect against any anticipated threats or hazards to the security or integrity of the information; and

c. Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.38(505) Examples of methods of development and implementation. The actions and procedures that follow are examples of methods a licensee may use to implement the requirements of rule 191—90.37(505) to assess, manage and control risks of disclosure:

1. Identify reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration or destruction of customer information or customer information systems.
2. Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information.
3. Assess the sufficiency of policies, procedures, customer information systems and other safeguards in place to control risks.
4. Design an information security program to control the identified risks, commensurate with the sensitivity of the information as well as the complexity and scope of the licensee's activities.
5. Train staff, as appropriate, to implement the licensee's information security program.
6. Regularly test or otherwise regularly monitor the key controls, systems and procedures of the information security program. The frequency and nature of these tests or other monitoring practices are determined by the licensee's risk assessment.
7. Exercise appropriate due diligence in selecting service providers.

8. Require service providers to implement appropriate measures designed to meet the objectives of rule 191—90.37(505) and, when indicated by the licensee's risk assessment, take appropriate steps to confirm that service providers have satisfied these obligations.

9. Monitor, evaluate and adjust, as appropriate, the information security program in light of any relevant changes in technology, the sensitivity of customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to customer information systems.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.39(505) Penalties. An insurer, producer or licensee that violates a requirement of these rules shall be subject to the penalties imposed under Iowa Code chapter 507B in addition to any other penalties provided by the laws of this state.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

191—90.40(505) Effective date. Each licensee shall establish and implement an information security program, including appropriate policies and systems, by June 30, 2003.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

These rules are intended to implement Iowa Code section 505.8(6) and P.L. 106-102.

APPENDIX A
SAMPLE CLAUSES

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1 Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirements of paragraph 90.5(1)*"a"* to describe the categories of nonpublic personal financial information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2 Categories of information that a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirements of paragraph 90.5(1)*"b"* to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in rules 191—90.14(505), 191—90.15(505), and 191—90.16(505).

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premiums, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect as described (describe location in the notice, such as "above" or "below").

A-3 Categories of information that a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of paragraphs 90.5(1)*"b,"* *"c,"* and *"d"* to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in rules 191—90.13(505) and 191—90.14(505).

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4 Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of paragraph 90.5(1)*"c"* to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses

nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by exceptions to rules 191—90.12(505), 191—90.13(505), and 191—90.14(505), as well as when permitted by the exceptions in rules 191—90.13(505) and 191—90.14(505).

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as (provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents");
- Nonfinancial companies, such as (provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"); and
- Others, such as (provide illustrative examples, such as "nonprofit organizations").

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5 Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of paragraph 90.5(1)*"e"* related to the exception for service providers and joint marketers in rule 191—90.12(505). If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premium, and pay history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described (describe location in the notice, such as "above" or "below"), to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6 Explanation of opt-out right (institutions that disclose outside of the exception)

A licensee may use this clause, as applicable, to meet the requirement of paragraph 90.5(1)*"f"* to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the methods by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in rules 191—90.12(505), 191—90.13(505), and 191—90.14(505).

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may (describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)").

A-7 Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of paragraph 90.5(1)*"h"* to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to (provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"). We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

[**ARC 7741C**, IAB 3/20/24, effective 4/24/24]

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EDUCATIONAL EXAMINERS BOARD[282]

[Prior to 6/15/88, see Professional Teaching Practices Commission[640]]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287]]

CHAPTER 1
GENERAL

CHAPTER 2
PETITIONS FOR RULE MAKING
(Uniform Rules)

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

CHAPTER 6
WAIVERS FROM ADMINISTRATIVE RULES

CHAPTER 11
COMPLAINTS, INVESTIGATIONS, CONTESTED CASE HEARINGS

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 2]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 2]

282—11.1(17A,256) Scope and applicability. This chapter applies to contested case proceedings conducted by the board of educational examiners.

282—11.2(17A) Definitions. Except where otherwise specifically defined by law:

"Board" means the board of educational examiners.

"Complainant" means any qualified party who files a complaint with the board.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

"Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

"Presiding officer" means an administrative law judge from the Iowa department of inspections and appeals or the full board or a three-member panel of the board.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the full board did not preside.

"Respondent" means any individual who is charged in a complaint with violating the criteria of professional practices or the criteria of competent performance.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.3(17A,256) Jurisdictional requirements.

11.3(1) The case must relate to alleged violation of the criteria of professional practices or the criteria of competent performance.

11.3(2) The magnitude of the alleged violation must be adequate to warrant a hearing by the board.

11.3(3) There must be sufficient evidence to support the complaint.

11.3(4) The complaint must be filed by a person who has personal knowledge of an alleged violation and must include a concise statement of facts which clearly and specifically apprises the respondent of the details of the allegation(s).

11.3(5) The complaint must be filed within three years of the occurrence of the conduct upon which it is based or discovery of the conduct by the complainant unless good cause can be shown for extension of this limitation.

11.3(6) The jurisdictional requirements must be met on the face of the complaint before the board may order an investigation of the allegation(s) of the complaint.

11.3(7) As an additional factor, it should appear that a reasonable effort has been made to resolve the problem on the local level. However, the absence of such an effort shall not preclude investigation by the board.

282—11.4(17A,256) Complaint.

11.4(1) *Who may initiate.* The following entities may initiate a complaint:

a. Licensed practitioners.

b. Recognized educational entities or local or state professional organizations.

c. Local boards of education.

d. Parents or guardians of students involved in the alleged complaint.

e. The executive director of the board of educational examiners if the following circumstances have been met:

(1) The executive director receives information that a practitioner:

1. Has been convicted of a felony criminal offense, or a misdemeanor criminal offense wherein the victim of the crime was 18 years of age or younger, and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

2. Has been the subject of a founded report of child abuse placed upon the central registry maintained by the department of human services pursuant to Iowa Code section 232.71D and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

3. Has not met a reporting requirement stipulated by Iowa Code section 256.160, Iowa Code section 279.43, 281—subrule 102.11(2), 282—Chapter 11, or 282—Chapter 25; or

4. Has falsified a license or authorization issued by the board; or

5. Has submitted false information on a license or authorization application filed with the board; or

6. Does not hold the appropriate license for the assignment for which the practitioner is currently employed; or

7. Has assigned another practitioner to perform services for which the practitioner is not properly licensed; or

8. Has failed to comply with a board order as prohibited by 282—paragraph 25.3(7)*"c"*; and

(2) The executive director verifies the information or the alleged misconduct through review of official records maintained by the board, a court, the department of human services registry of founded child abuse reports, the practitioner licensing authority of another state, the department of education, the local school district, area education agency, or authorities in charge of the nonpublic school, or the executive director is presented with the falsified license; and

(3) No other complaint has been filed.

f. The department of transportation if the licensee named in the complaint holds a behind-the-wheel instructor's certification issued by the department and the complaint relates to an incident or incidents arising during the course of driver's education instruction.

g. An employee of the department of education who, while performing official duties, becomes aware of any alleged misconduct by an individual licensed under Iowa Code section 256.146.

11.4(2) *Form and content of the complaint.*

a. The complaint shall be in writing and signed by at least one complainant who has personal knowledge of an alleged violation of the board's rules or related state law or an authorized representative if the complainant is an organization. (An official form may be used. This form may be obtained from the board upon request.)

b. The complaint shall show venue as "BEFORE THE BOARD OF EDUCATIONAL EXAMINERS" and shall be captioned "COMPLAINT."

c. The complaint shall contain the following information:

(1) The full name, address and telephone number of the complainant.

(2) The full name, address and telephone number, if known, of the respondent.

(3) A concise statement of the facts which clearly and specifically apprises the respondent of the details of the alleged violation of the criteria of professional practices or the criteria of competent performance and the relief sought by the complainant.

(4) An explanation of the basis of the complainant's personal knowledge of the facts underlying the complaint.

(5) A citation to the specific rule or law which the complainant alleges has been violated.

11.4(3) *Required copies—place and time of filing the complaint.*

a. A copy of the complaint must be filed with the board.

b. The complaint must be delivered personally or by mail to the office of the board. The current office address is 701 East Court Avenue, Suite A, Des Moines, Iowa 50309.

c. Timely filing is required in order to ensure the availability of witnesses and to avoid initiation of an investigation under conditions which may have been significantly altered during the period of delay.

The conduct upon which it is based must have occurred or been discovered by the complainant within three years of filing of the complaint unless good cause is shown for an extension of this limitation.

11.4(4) *Amendment or withdrawal of complaint.* A complaint or any specification thereof may be amended or withdrawn by the complainant at any time, unless the complaint was filed in accordance with the mandatory reporting requirements set forth in Iowa Code section 256.160(1). The parties to a complaint may mutually agree to the resolution of the complaint at any time in the proceeding prior to issuance of a final order by the board. The resolution must be committed to a written agreement and filed with the board. The agreement is not subject to approval by the board, but shall be acknowledged by the board and may be incorporated into an order of the board.

11.4(5) *Respondent entitled to copy of the complaint.* Immediately upon the board's determination that jurisdictional requirements have been met, the respondent shall be provided a copy of the complaint or amended complaint and any supporting documents attached to the complaint at the time of filing.

11.4(6) *Voluntary surrender of license—agreement to accept lesser sanction.* A practitioner may voluntarily surrender the practitioner's license or agree to accept a lesser sanction from the board prior to or after the filing of a complaint with the board without admitting the truth of the allegations of the complaint if a complaint is on file with the board. In order to voluntarily surrender a license or submit to a sanction, the practitioner must waive the right to hearing before the board and notify the board of the intent to surrender or accept sanction. The board may issue an order permanently revoking the practitioner's license if it is surrendered, or implementing the agreed upon sanction. The board may decline to issue an agreed upon sanction if, in the board's judgment, the agreed upon sanction is not appropriate for the circumstances of the case.

11.4(7) *Investigation of license reports.*

a. Reports received by the board from another state, territory or other jurisdiction concerning licenses or certificate revocation or suspension shall be reviewed and investigated by the board in the same manner as is prescribed in these rules for the review and investigation of written complaints.

b. Failure to report a license revocation, suspension or other disciplinary action taken by licensing authority of another state, territory or jurisdiction within 30 days of the final action by such licensing authority shall constitute cause for initiation of an investigation.

11.4(8) *Timely resolution of complaints.* Complaints filed with the board must be resolved within 180 days unless good cause can be shown for an extension of this limitation. The board will provide notice to the parties to a complaint prior to taking action to extend this time limitation upon its own motion.

11.4(9) *Confidentiality.* All complaint files, investigation files, other investigation reports, and other investigation information in the possession of the board or its employees or agents, which relate to licensee discipline, are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and are not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline. However, investigative information in the possession of the board or its employees or agents that is related to licensee discipline may be disclosed to appropriate licensing authorities within this state, the appropriate licensing authorities in another state, the District of Columbia, or a territory or country in which the licensee is licensed or has applied for a license. Records related to written complaints shall be collected and retained and shall be evaluated if a similar complaint has been filed against the same licensed practitioner. A finding of probable cause, a final written decision, and a finding of fact by the board in a disciplinary proceeding constitute a public record.

[**ARC 8406B**, IAB 12/16/09, effective 1/20/10 (See Delay note at end of chapter); **ARC 8823B**, IAB 6/2/10, effective 5/14/10; **ARC 0026C**, IAB 3/7/12, effective 4/11/12; **ARC 0853C**, IAB 7/24/13, effective 8/28/13; **ARC 1455C**, IAB 5/14/14, effective 6/18/14; **ARC 3196C**, IAB 7/5/17, effective 8/9/17; **ARC 4633C**, IAB 8/28/19, effective 10/2/19; **ARC 5320C**, IAB 12/16/20, effective 1/20/21; **ARC 7718C**, IAB 3/20/24, effective 4/24/24]

282—11.5(256) Investigation of complaints or license reports. The chairperson of the board or the chairperson's designee may request an investigator to investigate the complaint or report received by the board from another state, territory or other jurisdiction concerning license or certificate revocation or

suspension pursuant to subrule 11.4(7); providing that the jurisdictional requirements have been met on the face of the complaint. The investigation shall be limited to the allegations contained on the face of the complaint. The investigator may consult an assistant attorney general concerning the investigation or evidence produced from the investigation. Upon completion of the investigation, the investigator shall prepare a report of the investigation for consideration by the board in determining whether probable cause exists. The investigation of the complaint shall be finalized even if the licensed practitioner resigns or surrenders the practitioner's license, certificate, authorization, or statement of recognition during the investigation. The board shall investigate whether or not an administrator who is employed by the school that employs a licensed practitioner who is the subject of an investigation initiated under Iowa Code section 256.160(1)*"a"* filed a written complaint and whether or not the administrator was required to report to the board pursuant to Iowa Code section 256.160.
[**ARC 7718C**, IAB 3/20/24, effective 4/24/24]

282—11.6(256) Ruling on the initial inquiry. Upon review of the investigator's report, the board may take any of the following actions:

11.6(1) Reject the case. If a determination is made by the board to reject the case, the complaint shall be returned to the complainant along with a statement specifying the reasons for rejection. A letter of explanation concerning the decision of the board shall be sent to the respondent.

11.6(2) Require further inquiry. If determination is made by the board to order further inquiry, the complaint and recommendations by the investigator(s) shall be returned to the investigator(s) along with a statement specifying the information deemed necessary.

11.6(3) Accept the case. If a determination is made by the board that probable cause exists to conclude that the criteria of professional practices or the criteria of competent performance have been violated, notice may be issued, pursuant to rule 282—11.7(17A,256), and a formal hearing may be conducted in accordance with rules 282—11.7(17A,256) to 282—11.21(17A,256), unless a voluntary waiver of hearing has been filed by the respondent pursuant to the provisions of subrule 11.4(6). In determining whether to issue a notice of hearing, the board may consider the following:

a. Whether the alleged violation is of sufficient magnitude to warrant a hearing by the board.

b. Whether there is sufficient evidence to support the complaint.

c. Whether the alleged violation was an isolated incident.

d. Whether adequate steps have been taken at the local level to ensure similar behavior does not occur in the future.

11.6(4) Release of investigative report. If the board finds probable cause of a violation, the investigative report will be available to the respondent upon request. Information contained within the report is confidential and may be used only in connection with the disciplinary proceedings before the board.
[**ARC 1543C**, IAB 7/23/14, effective 8/27/14]

282—11.7(17A,256) Notice of hearing.

11.7(1) *Delivery.* Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

a. Personal service as provided in the Iowa Rules of Civil Procedure; or

b. Certified mail, return receipt requested; or

c. Publication, as provided in the Iowa Rules of Civil Procedure.

11.7(2) *Contents.* The notice of hearing shall contain the following information:

a. A statement of the time, date, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the particular sections of the statutes and rules involved;

d. A short and plain statement of the matter asserted;

e. Identification of all parties including the name, address and telephone numbers of counsel representing each of the parties where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer; and

h. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11 and rule 282—11.8(17A,256), that the presiding officer be an administrative law judge.

[**ARC 0606C**, IAB 2/20/13, effective 3/27/13]

282—11.8(17A,256) Presiding officer.

11.8(1) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days after service of a notice of hearing which identifies or describes the presiding officer as the board.

11.8(2) The board may deny the request only upon a finding that one or more of the following apply:

a. Neither the board nor any officer of the board under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.

b. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.

c. An administrative law judge with the qualifications identified in subrule 11.8(4) is unavailable to hear the case within a reasonable time.

d. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

e. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

f. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.

g. The request was not timely filed.

h. The request is not consistent with a specified statute.

11.8(3) The board shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 11.8(4), the parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

11.8(4) An administrative law judge assigned to act as presiding officer in a contested case shall have the following technical expertness unless waived by the board:

a. A J.D. degree.

b. Additional criteria may be added by the board.

11.8(5) Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the board. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

11.8(6) Unless otherwise provided by law, the board, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

282—11.9(17A,256) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the board in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

282—11.10(17A,256) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

282—11.11(17A,256) Disqualification.

11.11(1) A presiding officer or board member shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

a. Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

11.11(2) The term "personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 11.11(3) and 11.24(9).

11.11(3) In a situation where a presiding officer or board member knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

11.11(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 11.11(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If the presiding officer determines that disqualification is appropriate, the presiding officer or board member shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 282—11.26(17A,256) and seek a stay under rule 282—11.30(17A,256).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.12(17A,256) Consolidation—severance.

11.12(1) *Consolidation.* The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

11.12(2) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

282—11.13(17A,256) Pleadings.

11.13(1) Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

11.13(2) Answer. An answer shall be filed within 20 days of service of the notice of hearing unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the notice of hearing to which it responds. It shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

Any allegation in the notice of hearing not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

11.13(3) Amendment. Notices of hearing and answers may be amended with the consent of the parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

282—11.14(17A,256) Service and filing of pleadings and other papers.

11.14(1) *Service—when required.* Except where otherwise provided by law, every document filed in a contested case proceeding shall be served upon each of the parties of record to the proceeding, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

11.14(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

11.14(3) *Filing—when required.* After the notice of hearing, all documents in a contested case proceeding shall be filed with the Board of Educational Examiners, 701 East Court Avenue, Suite A, Des Moines, Iowa 50309. All documents that are required to be served upon a party shall be filed simultaneously with the board.

11.14(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board, delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

11.14(5) *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).
>
> (Date) (Signature)

[**ARC 5320C**, IAB 12/16/20, effective 1/20/21]

282—11.15(17A,256) Discovery.

11.15(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

11.15(2) Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule

11.15(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

11.15(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible under rule 282—11.22(17A,256). In discovery matters, the parties shall honor the rules of privilege imposed by law.

282—11.16(17A,256) Subpoenas.

11.16(1) *Subpoenas.* In connection with the investigation set forth in rule 282—11.5(256), the board is authorized by law to subpoena books, papers, records and any other evidence to help it determine whether it should institute a contested case proceeding (hearing). After service of the hearing notification contemplated by rule 282—11.7(17A,256), the following procedures are available to the parties in order to obtain relevant and material evidence:

a. Board subpoenas for books, papers, records, and other evidence will be issued to a party upon request. Such a request must be in writing. Application should be made to the board office specifying the evidence sought. Subpoenas for witnesses may also be obtained.

b. Evidence obtained by subpoena shall be admissible at the hearing if it is otherwise admissible under rule 282—11.22(17A,256). In subpoena matters the parties shall honor the rules of privilege imposed by law.

c. The evidence outlined in Iowa Code section 17A.13(2) where applicable and relevant shall be made available to a party upon request.

d. Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

11.16(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

282—11.17(17A,256) Motions.

11.17(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

11.17(2) Any party may file a written response to a motion within 15 days after the motion is served, unless the time period is extended or shortened by rules of the agency or the presiding officer.

11.17(3) The presiding officer may schedule oral arguments on any motion.

11.17(4) Motions pertaining to the hearing, including motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

[**ARC 6129C**, IAB 1/12/22, effective 2/16/22]

282—11.18(17A,256) Prehearing conference.

11.18(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be conducted not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause the presiding officer may permit variances from this rule.

11.18(2) Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

11.18(3) In addition to the requirements of subrule 11.18(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters which will expedite the hearing.

11.18(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

282—11.19(17A,256) Continuances. A party has no automatic right to a continuance or delay of the board's hearing procedure or schedule. However, a party may request a continuance of the presiding officer no later than seven days prior to the date set for hearing. The presiding officer shall have the power to grant continuances. Within seven days of the date set for hearing, no continuances shall be granted except for extraordinary, extenuating or emergency circumstances. In these situations, the presiding officer shall grant continuances after consultation, if needed, with the chairperson of the board, the executive director, or the attorney representing the board. A board member shall not be contacted in person, by mail or telephone by a party seeking a continuance.

282—11.20(17A,256) Intervention.

11.20(1) *Motion.* A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

11.20(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

11.20(3) *Grounds for intervention.* The movant shall demonstrate that: (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

11.20(4) *Effect of intervention.* If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

282—11.21(17A,256) Hearing procedures.

11.21(1) The presiding officer presides at the hearing and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings. If the presiding officer is the board or a panel thereof, an administrative law judge from the Iowa department of inspections and appeals may be designated to assist the board in conducting proceedings under this chapter. An administrative law judge so designated may rule upon motions and other procedural matters and assist the board in conducting the hearing.

11.21(2) All objections shall be timely made and stated on the record.

11.21(3) Legal representation.

a. The respondent has a right to participate in all hearings or prehearing conferences and may be represented by an attorney or another person authorized by law.

b. The office of the attorney general or an attorney designated by the executive director shall be responsible for prosecuting complaint allegations in all contested case proceedings before the board, except those cases in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations. The assistant attorney general or other designated attorney assigned to prosecute a contested case before the board shall not represent the board or the complainant in that case, but shall represent the public interest.

c. In a case in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations, the person who files the complaint with the board, or the complainant's designee, shall represent the complainant during the contested case proceedings.

11.21(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

11.21(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

11.21(6) Witnesses may be sequestered during the hearing.

11.21(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

282—11.22(17A,256) Evidence.

11.22(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

11.22(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

11.22(3) Evidence in the proceeding shall be confined to the issues concerning allegations raised on the face of the complaint as to which the parties received notice prior to the hearing.

11.22(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

11.22(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

11.22(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

282—11.23(17A,256) Default.

11.23(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

11.23(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

11.23(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 282—11.28(17A,256). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

11.23(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

11.23(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

11.23(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

11.23(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 282—11.26(17A,256).

11.23(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

11.23(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues (but, unless the defaulting party has appeared, it cannot exceed the relief demanded).

11.23(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 282—11.30(17A,256).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.24(17A,256) Ex parte communication.

11.24(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the board or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 11.11(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

11.24(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

11.24(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

11.24(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 282—11.13(17A,256) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

11.24(5) Board members acting as presiding officers may communicate with each other without notice or opportunity for parties to participate.

11.24(6) The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 11.24(1).

11.24(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 282—11.19(17A,256).

11.24(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order (or disclosed). If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

11.24(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

11.24(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the department. Violation of ex parte communication prohibitions by department personnel shall be reported to (agency to designate person to whom violations should be reported) for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

282—11.25(17A,256) Recording costs. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

282—11.26(17A,256) Interlocutory appeals. Upon written request of a party or on its own motion, the board may review an interlocutory order of the presiding officer. In determining whether to do so, the board shall weigh the extent to which its granting the interlocutory appeal would expedite final

resolution of the case and the extent to which review of that interlocutory order by the board at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

282—11.27(17A,256) Final decision.

11.27(1) When the board presides over the reception of evidence at the hearing, its decision is a final decision.

11.27(2) When the board does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 282—11.28(17A,256).

282—11.28(17A,256) Appeals and review.

11.28(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

11.28(2) *Review.* The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

11.28(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

11.28(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

11.28(5) *Scheduling.* The board shall issue a schedule for consideration of the appeal.

11.28(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs.

The board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

282—11.29(17A,256) Applications for rehearing.

11.29(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

11.29(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the board decision on the existing record and whether, on the basis of the grounds enumerated in subrule 11.28(4), the applicant requests an opportunity to submit additional evidence.

11.29(3) *Time of filing.* The application shall be filed with the board within 20 days after issuance of the final decision.

11.29(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

11.29(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

282—11.30(17A,256) Stays of board actions.

11.30(1) *When available.*

a. Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The executive director may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the board for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

11.30(2) *When granted.* In determining whether to grant a stay, the executive director or presiding officer shall consider the factors listed in Iowa Code section 17A.19(5).

11.30(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the board or any other party.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.31(17A,256) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

282—11.32(17A,256) Emergency adjudicative proceedings.

11.32(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the board may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the board by emergency adjudicative order. Before issuing an emergency adjudicative order the board shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the board is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the board is necessary to avoid the immediate danger.

11.32(2) *Issuance of order.*

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the board's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the board;

(3) Certified mail to the last address on file with the board;

(4) First-class mail to the last address on file with the board; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that board orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

11.32(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

11.32(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the board shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which board proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further board proceedings to a later date will be granted only in compelling circumstances upon application in writing.

282—11.33(256) Methods of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revoke a practitioner's license, certificate or authorization.

2. Suspend a practitioner's license, certificate or authorization until further order of the board or for a specific period.

3. Prohibit permanently, until further order of the board, or for a specific period, a practitioner from engaging in specified practices, methods, or acts.

4. Require additional education or training.

5. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.

6. Issue a public letter of reprimand.

7. Order any other resolution appropriate to the circumstances of the case.

8. Impose fees as provided in Iowa Code section 256.146(23).

[**ARC 6130C**, IAB 1/12/22, effective 2/16/22]

282—11.34(256) Reinstatement. Any person whose license, certificate or authorization to practice has been suspended may apply to the board for reinstatement in accordance with the terms and conditions of the order of the suspension.

11.34(1) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for reinstatement. Such application shall be docketed in the original case in which the license, certificate or authorization was suspended. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the board.

11.34(2) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the suspension of the respondent's license, certificate or authorization no longer exists and that it will be in the public interest for the license, certificate or authorization to be reinstated. The burden of proof to establish such facts shall be on the respondent.

11.34(3) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of fact and conclusions of law.

282—11.35(256) Application denial and appeal. The executive director is authorized by Iowa Code section 256.151 to grant or deny applications for licensure. If the executive director denies an application for an initial or exchange license, certificate, or authorization, the executive director shall send to the applicant by regular first-class mail written notice identifying the factual and legal basis for denying the application. If the executive director denies an application to renew an existing license, certificate, or authorization, the provisions of rule 282—11.36(256) shall apply.

11.35(1) *Mandatory grounds for license denial.* The executive director shall deny an application based on the grounds set forth in Iowa Code section 256.146(13), including:

a. The license application is fraudulent.

b. The applicant's license or certification from another state is suspended or revoked.

c. The applicant fails to meet board standards for application or for license renewal.

d. The applicant is less than 21 years of age, except that a coaching authorization or paraeducator certificate may be issued to an applicant who is 18 years of age or older, as provided in Iowa Code sections 256.157 and 256.165. A student enrolled in a practitioner preparation program who meets board requirements for a temporary, limited purpose license and who is seeking to teach as part of the practicum or internship may be less than 21 years of age.

e. The applicant has been convicted of one of the disqualifying criminal convictions set forth in paragraph 11.35(2)*"a."*

11.35(2) *Conviction of a crime and founded child abuse.*

a. Disqualifying criminal convictions. The board shall deny an application for licensure if the applicant or licensee has been convicted, has pled guilty to, or has been found guilty of the following criminal offenses, regardless of whether the judgment of conviction or sentence was deferred:

(1) Any of the following forcible felonies included in Iowa Code section 702.11: child endangerment, assault, murder, sexual abuse, or kidnapping;

(2) Any of the following criminal sexual offenses, as provided in Iowa Code chapter 709, involving a child:

1. First-, second- or third-degree sexual abuse committed on or with a person who is under the age of 18;
2. Lascivious acts with a child;
3. Assault with intent to commit sexual abuse;
4. Indecent contact with a child;
5. Sexual exploitation by a counselor;
6. Lascivious conduct with a minor;
7. Enticing a minor under Iowa Code section 710.10; or
8. Human trafficking under Iowa Code section 710A.2;

(3) Incest involving a child as prohibited by Iowa Code section 726.2;

(4) Dissemination and exhibition of obscene material to minors as prohibited by Iowa Code section 728.2;

(5) Telephone dissemination of obscene material to minors as prohibited by Iowa Code section 728.15;

(6) Any offense specified in the laws of another jurisdiction, or any offense that may be prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a"*; or

(7) Any offense under prior laws of this state or another jurisdiction, or any offense under prior law that was prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a."*

b. Other criminal convictions and founded child abuse. When determining whether a person should be denied licensure based on the conviction of any other crime, including a felony, or a founded report of child abuse, the executive director and the board shall consider the following:

(1) The nature and seriousness of the crime or founded abuse in relation to the position sought;

(2) The time elapsed since the crime or founded abuse was committed;

(3) The degree of rehabilitation which has taken place since the crime or founded abuse was committed;

(4) The likelihood that the person will commit the same crime or abuse again;

(5) The number of criminal convictions or founded abuses committed; and

(6) Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

c. Speech and intellectual freedom protections. The board may deny a license to or revoke the license of a person upon the board's finding by a preponderance of evidence that the person knowingly and intentionally discriminated against a student in violation of Iowa Code section 261H.2(3) or 279.73.

11.35(3) *Fraudulent applications.* An application shall be considered fraudulent pursuant to Iowa Code section 256.146(13)*"b"*(3) if it contains any false representation of a material fact or any omission of a material fact which should have been disclosed at the time of application for licensure or is submitted with a false or forged diploma, certificate, affidavit, identification, or other document material to the applicant's qualification for licensure or material to any of the grounds for denial set forth in Iowa Code section 256.146(13).

11.35(4) *Appeal procedure.*

a. An applicant who is aggrieved by the denial of an application for licensure and who desires to challenge the decision of the executive director must appeal the decision and request a hearing before the board within 30 calendar days of the date the notice of license denial is mailed. An appeal and request for hearing must be in writing and is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service to the board office. The request for hearing shall specify the factual or legal errors the applicant contends were made by the executive director, must identify any factual disputes upon which the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure. If a request for hearing is timely made, the executive director shall promptly issue a notice of contested case hearing on the grounds asserted by the applicant.

b. The board, in its discretion, may act as presiding officer at the contested case hearing, may hold the hearing before a panel of three board members, or may request that an administrative law judge act as presiding officer. The applicant may request that an administrative law judge act as presiding officer and render a proposed decision pursuant to rule 282—11.8(17A,256). A proposed decision by a panel of board members or an administrative law judge is subject to appeal or review by the board pursuant to rule 282—11.28(17A,256).

c. Hearings concerning licensure denial shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

d. On appeal, the board may grant or deny the application for licensure. If the application for licensure is denied, the board shall state the reason or reasons for the denial and may state conditions under which the application could be granted, if applicable.

11.35(5) *Judicial review.* Judicial review of a final order of the board denying licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case. In order to exhaust administrative remedies, an applicant aggrieved by the executive director's denial of an application for licensure must timely appeal the adverse decision to the board.

[**ARC 9209B**, IAB 11/3/10, effective 12/8/10; **ARC 0025C**, IAB 3/7/12, effective 4/11/12; **ARC 0026C**, IAB 3/7/12, effective 4/11/12; **ARC 6129C**, IAB 1/12/22, effective 2/16/22]

282—11.36(256) Denial of renewal application. If the executive director denies an application to renew a license, certificate or authorization, a notice of hearing shall be issued to commence a contested case proceeding. The executive director may deny a renewal application on the same grounds as those that apply to an application for initial or exchange licensure described in subrules 11.35(1) to 11.35(3).

11.36(1) *Hearing procedure.* Hearings on denial of an application to renew a license shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. The provisions of subrules 11.35(4) and 11.35(5) shall apply.

11.36(2) *Judicial review.* Judicial review of a final order of the board denying renewal of licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case.

11.36(3) *Impact of denial of renewal application.* Pursuant to Iowa Code section 17A.18(2), if the licensee has made timely and sufficient application for renewal, an existing license shall not expire until the last day for seeking judicial review of the board's final order denying the application or a later date fixed by order of the board or reviewing court.

11.36(4) *Timeliness of renewal application.* Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

a. Received by the board on or before the date the license is set to expire or lapse;

b. Signed by the licensee if submitted in paper form or certified as accurate if submitted electronically;

c. Fully completed; and

d. Accompanied by the proper fee. The fee shall be deemed improper if the amount is incorrect, the fee was not included with the application, or the licensee's check is unsigned or returned for insufficient funds.

282—11.37(256) Mandatory reporting of contract nonrenewal or termination or resignation based on allegations of misconduct. The board of directors of a school district or area education agency, the superintendent of a school district or the chief administrator of an area education agency, and the authorities in charge of a nonpublic school shall report to the board any instance of disciplinary action taken against a person who holds a license, certificate, or authorization issued by the board for conduct that would constitute a violation of 282—subparagraph 25.3(1)*"e"*(4), subrule 25.3(2), paragraph 25.3(3)*"e,"* or paragraph 25.3(4)*"b."* In addition, the board of directors of a school district or area education agency, the superintendent of a school district or the chief administrator of an area education agency, and the authorities in charge of a nonpublic school shall report to the board the nonrenewal or termination, for reasons of alleged or actual misconduct, of a person's contract executed under Iowa Code sections 279.12, 279.13, 279.15, 279.16, 279.18 through 279.21, 279.23, and 279.24, and the resignation of a person who holds a license, certificate, or authorization issued by the board as a result of or following an incident or allegation of misconduct that, if proven, would constitute a violation of 282—subparagraph 25.3(1)*"b"*(1), subparagraph 25.3(1)*"e"*(4), subrule 25.3(2), paragraph 25.3(3)*"e,"* or paragraph 25.3(4)*"b,"* when the board or reporting official has a good-faith belief that the incident occurred or the allegation is true.

11.37(1) *Method of reporting.* The report required by this rule may be made by completion and filing of the complaint form described in subrule 11.4(2) or by the submission of a letter to the executive director of the board which includes:

a. The full name, address, telephone number, title and signature of the reporter;

b. The full name, address, and telephone number of the person who holds a license, certificate or authorization issued by the board;

c. A concise statement of the circumstances under which the termination, nonrenewal, or resignation occurred;

d. The date action was taken which necessitated the report, including the date of disciplinary action taken, nonrenewal or termination of a contract for reasons of alleged or actual misconduct, or resignation of a person following an incident or allegation of misconduct as required under Iowa Code section 256.160(1), or awareness of alleged misconduct as required under Iowa Code section 256.160(2); and

e. Any additional information or documentation which the reporter believes will be relevant to assessment of the report pursuant to subrule 11.37(4).

11.37(2) *Timely reporting required.* The report required by this rule shall be filed within 30 days of the date action was taken which necessitated the report or within 30 days of an employee becoming aware of the alleged misconduct under Iowa Code section 256.160(2).

11.37(3) *Confidentiality of report.* Information reported to the board in accordance with this rule is privileged and confidential, and, except as provided in Iowa Code section 256.158, is not subject to discovery, subpoena, or other means of legal compulsion for its release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and is not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline.

11.37(4) *Action upon receipt of report.*

a. Upon receipt of a report under this rule, the executive director of the board shall review the information reported to determine whether a complaint investigation should be initiated.

b. In making this determination, the executive director shall consider the nature and seriousness of the reported misconduct in relation to the position sought or held, the time elapsed since the misconduct, the degree of rehabilitation, the likelihood that the individual will commit the same misconduct again, and the number of reported incidents of misconduct.

c. If the executive director determines a complaint should not be initiated, no further formal action will be taken and the matter will be closed.

d. If the executive director determines a complaint investigation should be initiated, the executive director shall assign the matter for investigation pursuant to rule 282—11.5(256).

11.37(5) *Proceedings upon investigation.* From the time of initiation of an investigation, the matter will be processed in the same manner as a complaint filed under rule 282—11.4(17A,256).

[**ARC 4699C**, IAB 10/9/19, effective 11/13/19]

282—11.38(256) Reporting by department of education employees.

11.38(1) *Method of reporting.* A report of misconduct made by the director, pursuant to Iowa Code section 256.9(52), or made by an employee of the department of education, pursuant to Iowa Code section 256.160(2), shall comply with the requirements of subrule 11.37(1).

11.38(2) *Confidentiality.* Information reported to the board in accordance with this rule is privileged and confidential, except as provided in Iowa Code section 256.158.

11.38(3) *Review and investigation of report.* The report shall be reviewed and investigated pursuant to subrules 11.37(4) and 11.37(5).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.39(256) Denial of application during a pending professional practices case. The executive director may deny an application for a Class B license if the applicant is currently under investigation and probable cause has been determined by the board.

[**ARC 9659B**, IAB 8/10/11, effective 9/14/11]

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[Filed ARC 4633C (Notice ARC 4503C, IAB 6/19/19), IAB 8/28/19, effective 10/2/19]
[Filed ARC 4699C (Notice ARC 4560C, IAB 7/31/19), IAB 10/9/19, effective 11/13/19]
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[Filed ARC 6130C (Notice ARC 5938C, IAB 10/6/21), IAB 1/12/22, effective 2/16/22]
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[1] Effective date of 282—Ch 11 delayed 45 days by the Administrative Rules Review Committee at its meeting held March 10, 2000; delay lifted by the Committee at its meeting held April 7, 2000, effective April 8, 2000.

[2] Two ARCs

[3] Effective date of ARC 8406B delayed until the adjournment of the 2010 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held January 5, 2010.

CHAPTER 12
FEES

282—12.1(256) Issuance of licenses, certificates, authorizations, and statements of professional recognition. All application and licensure fees are nonrefundable. The fee for the issuance of a license, certificate, statement of professional recognition, or authorization shall be $85 unless otherwise specified below:

1. Class E emergency license shall be $150.
2. Paraeducator certificate shall be $40.
3. Behind-the-wheel authorization shall be $40.
4. Military exchange license shall not require a fee for issuance.

[**ARC 9743B**, IAB 9/7/11, effective 10/12/11; **ARC 2017C**, IAB 6/10/15, effective 7/15/15; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 5304C**, IAB 12/2/20, effective 1/6/21]

282—12.2(256) Fees for the renewal or extension of licenses, certificates, statements of professional recognition, and authorizations. The fee for the renewal or extension of a license, certificate, statement of professional recognition, or authorization shall be $85 unless otherwise specified below:

1. The renewal of the paraeducator certificate shall be $40.
2. The renewal of the behind-the-wheel authorization shall be $40.
3. A one-year extension for renewal of a coaching authorization shall be $40.
4. A one-year extension of the initial license shall be $25. This extension may be issued if the applicant needs one additional year to meet the experience requirement for the standard license, but has met Iowa teaching standards, pursuant to rule 282—20.4(256).
5. The fee shall be $25 for an extension of the initial administrator license, which may be issued instead of renewing the initial administrator license if the applicant verifies one of the criteria listed in 282—subrule 20.8(2).
6. The fee for the renewal of a license, certificate, statement of professional recognition, or authorization for practitioners with a master's degree or higher who have ten or more years of experience in education shall be $50.

[**ARC 9743B**, IAB 9/7/11, effective 10/12/11; **ARC 2017C**, IAB 6/10/15, effective 7/15/15; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 7719C**, IAB 3/20/24, effective 4/24/24]

282—12.3(256) Evaluation fee. Each application from an out-of-state institution for initial licensure shall include, in addition to the basic fee for the issuance of a license, a one-time nonrefundable $60 evaluation fee.

[**ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

282—12.4(256) Adding endorsements.

12.4(1) *Fee for each added endorsement.* The fee for each additional endorsement to a license following the issuance of the initial license and endorsement(s) shall be $50. The fee for each additional endorsement added to a paraeducator certificate shall be $25.

12.4(2) *Fee for transcript review.* Applicants may ask the board of educational examiners to analyze transcripts if the applicant believes all requirements have been met. Applicants who request board of educational examiners transcript analysis shall be assessed a $60 transcript evaluation fee for each new endorsement requested. This fee shall be in addition to the fee for adding the endorsement.

[**ARC 2017C**, IAB 6/10/15, effective 7/15/15; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

282—12.5(256) Duplicate licenses, authorizations, and statements of professional recognition. The fee for the issuance of a duplicate practitioner's license, certificate, statement of professional recognition, or authorization shall be $15.

[**ARC 2017C**, IAB 6/10/15, effective 7/15/15; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

282—12.6(256) Late fees.

12.6(1) An additional fee of $25 per calendar month, not to exceed $150, shall be imposed if an application for renewal or conversion is submitted after the date of expiration of a practitioner's license. Waiver of the late fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

12.6(2) Failure to hold an endorsement. An additional fee of $25 per calendar month, not to exceed $150, shall be imposed if the practitioner holds a valid Iowa license but does not hold an endorsement for the type of service for which the practitioner is employed.

12.6(3) Failure to hold valid Iowa license or authorization. An additional fee of $100 per calendar month, not to exceed $500, shall be imposed if the practitioner does not hold a valid Iowa license or authorization. The fee will begin to be assessed on the first day of the school year for which the practitioner is employed until the practitioner submits a completed application packet for the appropriate license. The penalty will enforce Iowa Code section 256.151. Waiver of the fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

[**ARC 2017C**, IAB 6/10/15, effective 7/15/15; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

282—12.7(256) Fees nonrefundable. All fees as set out in this chapter are nonrefundable.

282—12.8(256) Portfolio review and evaluation fee. For the professional education core, the portfolio review and evaluation fee shall be $500.

[**ARC 8606B**, IAB 3/10/10, effective 4/14/10; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

282—12.9(256) Retention of incomplete applications.

12.9(1) *Timeline for complete application materials to be submitted.* Upon receipt of an incomplete application, the executive director will send a letter of deficiencies to the applicant stipulating that complete application materials must be submitted to the board office within 45 days of the date the letter is received. If the materials are not received within that timeline, the application process will be closed. If the applicant submits information after the 45-day deadline, the application process requires submission of a complete set of application materials and fees, including late fees if applicable, for practicing with an expired license, without the proper endorsement, or without an Iowa board-issued license.

12.9(2) *Background check.* The background check fee will be valid for one year. If a license is not issued within one year of a completed background check, the background check shall be considered void.

12.9(3) *Timeline for audited online renewals.* Upon receipt of notification that the online renewal application has been audited, the applicant shall have 30 days to submit the official transcripts and mandatory reporter verification to the board office. If the materials are not received within that timeline, the applicant will be notified that the application process is closed. If the applicant submits information after the 30-day deadline, the application process requires submission of a complete set of application materials and fees. If the license expires during the 30-day deadline and the applicant is teaching, the school district will be notified that the applicant's license is expired and the individual shall not continue teaching until the complete application materials are submitted to the board office.

12.9(4) *Request for additional time.* If the applicant is not able to submit the application materials by the deadline, the applicant may contact the executive director with a request for additional time. The applicant must submit verification as to the need for the additional time. The executive director will review the request and provide a written decision either approving or denying the request.

[**ARC 9386B**, IAB 2/23/11, effective 3/30/11; **ARC 2017C**, IAB 6/10/15, effective 7/15/15]

282—12.10(256) Fees for processing complaints and conducting hearings.

12.10(1) *Administrator licensure sanction.* If an administrator is a respondent in a complaint for violation of the code of professional conduct and ethics and the final board action results in a sanction, the administrator will be required to pay the fees that were related to processing the complaint and conducting the hearing. Such fees may include a fee for personal service by a sheriff, a fee for legal

notice when placed in a newspaper, a fee for transcription service or court reporter fee, and other fees assessed as costs by the board.

12.10(2) *Timeline for payment and board order.* Fees must be submitted to the board office within 45 days from the issuance of the letter outlining the required fees. Payment of fees may be imposed as a board order.

[**ARC 6130C**, IAB 1/12/22, effective 2/16/22]

These rules are intended to implement Iowa Code chapter 256.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]
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[Filed ARC 7719C (Notice ARC 7193C, IAB 12/13/23), IAB 3/20/24, effective 4/24/24]

[1] December 16, 2015, effective date of ARC 2229C [12.1 to 12.6, 12.8] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2015.

[2] See SJR 2007 of the 2016 Session of the Eighty-sixth General Assembly regarding nullification of the amendments to 12.1 to 12.6 and 12.8 (ARC 2229C, IAB 11/11/15). Prior language restored IAC Supplement 4/27/16.

MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 13
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

13.1(1) A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

13.1(2) A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

13.1(3) The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

13.1(4) A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

653—13.2(124,148,272C) Standards of practice—appropriate pain management. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy, including but not limited to adjunct therapies such as acupuncture, physical therapy and massage, osteopathic manipulative therapy and occupational therapy in the treatment of acute and chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.
2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.
3. The board recognizes that pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.
4. Physicians should not fear board action for treating pain with opioids as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.
5. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

13.2(1) *Definitions.* For the purposes of this rule, the following terms are defined as follows:

"Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"Addiction" means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors

that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"Chronic pain" means pain that typically lasts longer than three months or past the time of normal tissue healing. Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause.

"Opioid" means any U.S. Food and Drug Administration (FDA)-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

"Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

"Physical dependence" means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

"Substance abuse" means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

"Tolerance" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Undertreatment of pain" means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

13.2(2) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

13.2(3) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician's concern with addicting the patient, or a failure to use an adequate level of pain management.

13.2(4) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient's medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain.

c. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. A

physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the CDC Guideline for Prescribing Opioids for Chronic Pain.

13.2(5) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for opioids from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of opioids with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral. A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, and other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements. A physician who treats patients for chronic pain with opioids shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with opioids. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes opioids to a patient for more than 90 days for the treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. Sample pain management agreement and prescription drug risk assessment tools may be found on the board's website at www.medicalboard.iowa.gov.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care. The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

13.2(6) *Pain management for terminal illness.* The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

13.2(7) *Prescription monitoring program.* The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections 124.551 to 124.558 to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. A physician shall register for the prescription monitoring program at the same time the physician applies for registration or renews registration to prescribe controlled substances as required by the Iowa board of pharmacy. A physician or the physician's designated agent shall utilize the prescription monitoring program prior to issuing an opioid prescription to assist the physician in determining appropriate treatment options and to improve the quality of patient care. A physician is not required to utilize the prescription monitoring program to assist in the treatment of a patient receiving inpatient hospice care or long-term residential facility patient care. An order issued in an inpatient hospital setting is not considered a prescription for the purposes of these rules. Patient safety is adequately protected in an inpatient hospital setting, and physicians caring for patients in an inpatient hospital setting do not prescribe. A link to the prescription monitoring program may be found at the board's website at www.medicalboard.iowa.gov.

13.2(8) *Electronic prescriptions.* Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) shall be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

13.2(9) *Pain management resources.* The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the

convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain. On March 15, 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued a guideline to provide recommendations for the prescribing of opioid pain medication for patients 18 years of age and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than three months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

13.2(10) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 653—Chapter 23, or any of the following:

a. A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.

b. A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.

c. A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

13.2(11) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class "D" felony. This subrule shall not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.

This rule is intended to implement Iowa Code chapters 124, 148 and 272C.

[**ARC 9599B**, IAB 7/13/11, effective 8/17/11; **ARC 2705C**, IAB 9/14/16, effective 10/19/16; **ARC 4714C**, IAB 10/23/19, effective 11/27/19]

653—13.3(147) Supervision of pharmacists who administer adult immunizations. Rescinded **ARC 1033C**, IAB 10/2/13, effective 11/6/13.

653—13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management. Rescinded **ARC 6442C**, IAB 8/10/22, effective 9/14/22.

653—13.5(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147 and 148.

653—13.6(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

13.6(1) An internal quality control assurance plan shall include the following elements:

a. The name of the physician responsible for the internal quality assurance plan and testing;

b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;

c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;

d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;

e. Staff training and qualifications for dispensing via the dispensing system;

f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;

g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;

h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;

i. A plan for interval testing of the accuracy of dispensing, at least annually; and

j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

13.6(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

13.6(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph *"i."*

653—13.7(147,148,272C) Standards of practice—office practices.

13.7(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.7(2) *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

13.7(3) *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.7(4) *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor, regardless of whether the patient consents to that conduct.

13.7(5) *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

13.7(6) *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature which interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

13.7(7) *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

13.7(8) *Retention of medical records.*

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Beginning July 1, 2023, a physician must appoint another Iowa-licensed physician, or other representative or entity that is held to the same standards of confidentiality as the physician, to ensure that all requirements of this subrule are met in the event of the physician's death or incapacitation. Upon request by the board, the physician must be able to establish by sufficient proof the appointment of a representative pursuant to this paragraph.

d. Upon a physician's death or retirement, the sale of a medical practice, or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician or the physician's representative shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

[**ARC 6683C**, IAB 11/30/22, effective 1/4/23]

653—13.8(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa.

13.8(1) *Definitions.* As used in this rule:

"Alter" means to change the cellular structure of living tissue.

"Capable of" means any means, method, device or instrument which, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

"Damage" means to cause a harmful change in the cellular structure of living tissue.

"Delegate" means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

"Medical aesthetic service" means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

"Medical director" means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

"Medical spa" means any entity, however organized, which is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice which is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

"Nonsuperficial" means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

"Qualified laser technician" means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

"Qualified licensed or certified nonphysician person" means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

"Supervision" means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

13.8(2) *Practice of medicine.* The performance of medical aesthetic services is the practice of medicine. A medical aesthetic service shall only be performed by qualified licensed or certified

nonphysician persons or qualified laser technicians if the service has been delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa.

13.8(3) *Medical director.* A physician who serves as medical director at a medical spa shall:

a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;

b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;

c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and

e. Be clearly identified as the medical director in all advertising activities, Internet websites and signage related to the medical spa.

13.8(4) *Delegated medical aesthetic service.* When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

a. Within the medical director's scope of practice and medical competence to supervise;

b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and

c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

13.8(5) *Supervision.* A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person's education, training, experience and ability;

b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services which are beyond the scope of that person's license or certification unless the person is supervised by a qualified supervising physician;

c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician at least four hours each week and that the regular supervision is documented;

d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;

f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;

g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;

h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;

j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or

certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

13.8(6) *Continuing medical education.* All medical directors, qualified licensed or certified nonphysician persons and qualified laser technicians who practice at a medical spa in Iowa shall complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

13.8(7) *Exceptions.* This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

13.8(8) *Physician assistants.* Nothing in this rule shall be interpreted to contradict or supersede the rules established in 645—Chapters 326 and 327.

[**ARC 9088B**, IAB 9/22/10, effective 10/27/10; **ARC 4247C**, IAB 1/16/19, effective 2/20/19]

653—13.9(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

13.9(1) *Definition.* As used in this rule:

"Interventional chronic pain management" means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

13.9(2) *Interventional chronic pain management.* The practice of interventional chronic pain management shall include the following:

a. Comprehensive assessment of the patient;

b. Diagnosis of the cause of the patient's pain;

c. Evaluation of alternative treatment options;

d. Selection of appropriate treatment options;

e. Termination of prescribed treatment options when appropriate;

f. Follow-up care; and

g. Collaboration with other health care providers.

13.9(3) *Practice of medicine.* Interventional chronic pain management is the practice of medicine.
[**ARC 8918B**, IAB 6/30/10, effective 8/4/10]

653—13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

13.10(1) *Definition.* As used in this rule:

"Abortion-inducing drug" means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

13.10(2) *Physical examination required.* A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination of the woman to determine, and document in the woman's medical record, the gestational age and intrauterine location of the pregnancy.

13.10(3) *Physician's physical presence required.* When inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided.

13.10(4) *Follow-up appointment required.* If an abortion is induced by an abortion-inducing drug, the physician inducing the abortion must schedule a follow-up appointment with the woman at the same facility where the abortion-inducing drug was provided, 12 to 18 days after the woman's use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman's medical condition. The physician shall use all reasonable efforts to ensure that the woman is aware of the follow-up appointment and that she returns for the appointment.

13.10(5) *Parental notification regarding pregnant minors.* A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L) adopted by the public health department.
[**ARC 1034C**, IAB 10/2/13, effective 11/6/13]

653—13.11(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

1. The board recognizes that technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.
2. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.
3. The board advises that licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.
4. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

13.11(1) *Definitions.* As used in this rule:

"Asynchronous store-and-forward transmission" means the collection of a patient's relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

"Board" means the Iowa board of medicine.

"In-person encounter" means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

"Licensee" means a medical physician or osteopathic physician licensed by the board.

"Telemedicine" means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an

audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

"Telemedicine technologies" means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

13.11(2) *Practice guidelines.* A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.11(3) *Iowa medical license required.* A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.11(4) *Standards of care and professional ethics.* A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.11(5) *Scope of practice.* A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

13.11(6) *Identification of patient and physician.* A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.11(7) *Physician-patient relationship.*

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

(1) The person with a health-related matter seeks assistance from a licensee;

(2) The licensee agrees to undertake diagnosis and treatment of the person; and

(3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

(1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;

(2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care; or

(3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

13.11(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast

to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.11(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.11(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.11(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.11(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.11(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.11(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.11(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

(1) Privacy;

(2) Health care personnel who will process messages;

(3) Hours of operation;

(4) Types of transactions that will be permitted electronically;

(5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;

(6) Archiving and retrieval; and

(7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.11(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies,

remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

a. The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act.

13.11(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.11(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.11(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.11(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;

e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;

f. Emergency situations in which the life or health of the patient is in imminent danger;

g. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;

h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and

i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

13.11(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.11(20).

13.11(22) *Medical abortion.* Nothing in this rule shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.

[**ARC 1983C**, IAB 4/29/15, effective 6/3/15]

653—13.12(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility.

13.12(1) Definition. For purposes of this rule:

"Authorized facility" means a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

13.12(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A.

13.12(3) A physician who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists.

[**ARC 2387C**, IAB 2/3/16, effective 3/9/16; **ARC 6941C**, IAB 3/8/23, effective 4/12/23]

653—13.13(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

13.13(1) *Exemption from discipline.* To the extent consistent with state law, the board shall not revoke, fail to renew, suspend, or take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

13.13(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

a. The patient has a terminal illness, attested to by the patient's treating physician.

b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).

c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.

d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.

e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

13.13(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase 1 of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

13.13(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

13.13(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.

b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.

c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.

d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description shall include the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device. The description shall be based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.

e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.

f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.

g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

13.13(6) *Assisting suicide.* This rule shall not be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

13.13(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of rule 653—13.13(144E,147,148,272C) or 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.

b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.

c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

This rule is intended to implement Iowa Code chapters 144E, 147, 148 and 272C.

[**ARC 3588C**, IAB 1/17/18, effective 2/21/18]

653—13.14(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

13.14(1) *Exemption from discipline.* A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

a. The treatment is provided after an examination is performed and informed consent is received from the patient.

b. The physician identifies a medical reason for recommending or providing the treatment.

c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.

d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

13.14(2) *Lyme disease.* According to the Centers for Disease Control and Prevention (CDC), Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks, commonly known as deer ticks. Typical symptoms include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system. Lyme disease is diagnosed based on symptoms, physical findings (e.g., a rash), and the possibility of exposure to infected ticks. Laboratory testing is helpful if used correctly and performed with validated methods. Steps to prevent Lyme disease include using insect repellent, removing ticks promptly, applying pesticides, and reducing tick habitat. The ticks that transmit Lyme disease can occasionally transmit other tick-borne diseases as well.

13.14(3) *Lyme disease treatment.* Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

13.14(4) *Tick-borne diseases.* According to the CDC, tick-borne diseases include:

a. Anaplasmosis is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

b. Babesiosis is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.

c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.

d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.

e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.

f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.

g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis* (*Rickettsia phillipi*) is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

13.14(5) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.

b. The physician fails to identify and document a medical reason for recommending or providing the treatment.

c. The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.

d. The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.

[**ARC 3589C**, IAB 1/17/18, effective 2/21/18]

653—13.15(124E,147,148,272C) Standards of practice—medical cannabidiol.

13.15(1) *Definitions.* For purposes of this rule:

"Board of medicine" means the board established pursuant to Iowa Code chapters 147 and 148.

"Bordering state" means the same as defined in Iowa Code section 331.910.

"Debilitating medical condition" means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
8. Parkinson's disease.
9. Chronic pain.
10. Ulcerative colitis.
11. Severe, intractable autism with self-injurious or aggressive behaviors.
12. Corticobasal degeneration.
13. Post-traumatic stress disorder.

"Department" means the Iowa department of public health.

"Form and quantity" means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

"Medical cannabidiol" means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

"Medical cannabidiol board" means the board established pursuant to Iowa Code section 124E.5.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

"Untreatable pain" means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

"Written certification" means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the

patient's primary care provider which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

13.15(2) *Written certification.* A physician who is a patient's primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

13.15(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

13.15(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

13.15(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

13.15(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient's possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

13.15(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 653—Chapter 23. Grounds for discipline include, but are not limited to, the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual's primary care provider.

b. The physician provides a patient a written certification without determining, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

This rule is intended to implement Iowa Code chapters 124E, 147, 148 and 272C.

[**ARC 3830C**, IAB 6/6/18, effective 7/11/18; **ARC 4248C**, IAB 1/16/19, effective 2/20/19; **ARC 4377C**, IAB 3/27/19, effective 5/1/19; **ARC 4658C**, IAB 9/11/19, effective 10/16/19; **ARC 5861C**, IAB 8/25/21, effective 9/29/21]

653—13.16(146A) Abortion prerequisites.

13.16(1) *Written certification.* At least 24 hours prior to performing an abortion, a physician shall obtain written certification from the pregnant woman of each prerequisite as required in Iowa Code sections 146A.1(1)*"a"* through 146A.1(1)*"d"*(1). The written certification shall list each required prerequisite separately and shall include a line for date and signature of the pregnant woman. The physician shall maintain a copy of the certification as part of the pregnant woman's medical records.

13.16(2) *Exceptions.* This rule shall not apply to abortions performed in a medical emergency, as provided in Iowa Code section 146A.1(2).

13.16(3) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code section 146A.1 may constitute grounds for discipline.

This rule is intended to implement Iowa Code section 146A.1.

[**ARC 6684C**, IAB 11/30/22, effective 1/4/23]

653—13.17(135L,146A,146E,147,148,272C) Standards of practice for physicians who perform or induce abortions—definitions—detection of fetal heartbeat—fetal heartbeat exceptions—discipline.

13.17(1) *Standards of practice.* This rule sets forth the standards of practice for physicians who perform or induce abortions. More information is contained in Iowa Code section 146E.2(5).

13.17(2) *Definitions.* As used in this rule or in Iowa Code chapter 146E:

"Private health agency" means any establishment, facility, organization, or other entity that is not owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

"Public health agency" means any establishment; facility; organization; administrative division; or entity that is owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, administrative divisions, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

"Standard medical practice" means the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of Iowa Code chapter 146E and this rule, "standard medical practice" includes employing the appropriate means of detection depending on the estimated gestational age of the unborn child and the condition of the woman and her pregnancy.

"The pregnancy is the result of a rape" means a circumstance in which the pregnancy is the result of conduct that would constitute an offense under Iowa Code section 709.2, 709.3, 709.4, or 709.4A when perpetrated against a female, regardless of where the conduct occurred.

"The pregnancy is the result of incest" means a circumstance in which a sex act occurs between closely related persons that involves a vaginal penetration that causes a pregnancy. The closely related persons must be related, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew. For purposes of this rule, a closely related person includes a stepparent, stepchild, or stepsibling, including siblings through adoption.

"Unborn child" means an individual organism of the species *Homo sapiens* from fertilization to live birth—that is, at all stages of development, including embryo and fetus.

"Woman" means a female individual regardless of her age.

13.17(3) *Detection of fetal heartbeat.* A physician who intends to perform or induce an abortion must determine via ultrasound whether the woman is carrying an unborn child with a detectable fetal heartbeat.

a. Obligation. The obligation under this rule requires a bona fide effort to detect a fetal heartbeat in the unborn child. This effort must be made in good faith and according to standard medical practice and reasonable medical judgment.

b. Method. The physician shall perform a transabdominal pelvic ultrasound on the woman to determine whether the unborn child has a detectable fetal heartbeat. This shall be performed in a manner consistent with standard medical practice, with real-time ultrasound equipment with a transducer of appropriate frequency. The equipment must be properly maintained and in proper functioning order.

13.17(4) *Fetal heartbeat exceptions.* The following applies to a physician who intends to perform or induce an abortion under a fetal heartbeat exception as defined in Iowa Code chapter 146E and this rule:

a. Incest or rape. For purposes of this rule, a pregnancy resulting from incest or rape may be reported within the appropriate time frame to a licensed physician whose services are retained for an abortion procedure.

(1) To determine whether the pregnancy is the result of incest, a physician who intends to perform or induce an abortion must use the following information:

1. Whether the sex act occurred between the woman and a closely related person, meaning, either legitimately or illegitimately, an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, including a stepparent, stepchild, or stepsibling to include an adopted sibling.
2. The date the act occurred.
3. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the act was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for incest applies. This information does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

(2) To determine whether the pregnancy is the result of a rape, a physician who intends to perform or induce an abortion must use the following information:

1. The date the sex act that caused the pregnancy occurred.
2. The age of the woman seeking an abortion at the time of that sex act.
3. Whether the sex act constituted a rape.
4. Whether the rape was perpetrated against the woman seeking an abortion.

5. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the rape was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for rape applies. This rule does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

b. Fetal abnormality. A certification from an attending physician that a fetus has a fetal abnormality that in the attending physician's reasonable medical judgment is incompatible with life must contain the following information:

(1) The diagnosis of the abnormality;

(2) The basis for the diagnosis, including the tests and procedures performed, the results of those tests and procedures, and why those results support the diagnosis; and

(3) A description of why the abnormality is incompatible with life.

The diagnosis and the attending physician's conclusion must be reached in good faith following a bona fide effort, consistent with standard medical practice and reasonable medical judgment, to determine the health of the fetus. The certification must be signed by the attending physician. A physician who intends to perform or induce an abortion may rely in good faith on a certification from an attending physician if the physician who intends to perform or induce an abortion has a copy of the certification. The certification must be included in the woman's medical records by the physician who intends to perform or induce an abortion.

13.17(5) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code chapter 146E may constitute grounds for discipline.

This rule is intended to implement Iowa Code chapter 146E.

[**ARC 7720C**, IAB 3/20/24, effective 4/24/24]

653—13.18 and **13.19** Reserved.

653—13.20(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association shall be utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

13.20(1) *Conflict of interest.* A physician should not provide medical services under terms or conditions which tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

13.20(2) *Fees.* Any fee charged by a physician shall be reasonable.

653—13.21(17A,147,148,272C) Waiver prohibited. Rules in this chapter are not subject to waiver pursuant to 653—Chapter 3 or any other provision of law.

[**ARC 5600C**, IAB 5/5/21, effective 6/9/21]

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