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 OF DIVISION

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

191—1.1(502,505) Organization. The insurance division is headed by the commissioner of insurance who is assisted by a first deputy commissioner and other deputy and assistant commissioners. The functions of the division are divided into five bureaus.

1.1(1) The administrative bureau provides staff support to the commissioner and is responsible for legal services, budgetary and personnel services. General oversight of the division operations is provided through interaction with the public, the insurance industry, and other state and federal agencies.

1.1(2) The company regulation bureau is responsible for the following:

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

b. Examining the financial condition of Iowa 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 financial examination and analysis standards.

c. Serving as a general insurance information repository and resource for both insurers and consumers regarding, for example: insurance companies' status, addresses, telephone numbers, certifications, and financial statements; statutory construction; guaranty fund calculations; powers of attorney; compilation of statistics; and publication of annual governor's report.

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.

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.

1.1(3) The market regulation bureau is responsible for the following:

a. Ensuring fair treatment of consumers and preventing unfair or deceptive trade practices in the insurance and securities marketplaces. Inquiries from the public are answered and consumer complaints regarding insurance producers, insurers, broker-dealers, securities agents, investment advisers, and investment adviser representatives are received, reviewed, and investigated. Administrative actions are taken where appropriate, and criminal matters are referred to prosecutors for potential action.

b. Operating the senior health insurance information program (SHIIP), which provides training to senior volunteers throughout the state. These volunteers then provide free, confidential health insurance counseling to Iowa seniors. Issues addressed include Medicare, Medicare subscription drug coverage, Medicare supplement insurance, long-term care insurance, insurance claims, and all other health insurance policies. This program is primarily funded by a Centers for Medicare and Medicaid Services grant.

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

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

e. Licensing insurance producers and overseeing the continuing education that insurance producers are required to complete.

f. Monitoring surplus lines placement, registering purchasing groups, and overseeing the payment of premium taxes for surplus lines business including that which is placed through purchasing groups and risk retention groups.

g. Registering managing general agents and legal expense insurers.

h. Registering and monitoring third-party administrators.

i. Registering and monitoring health maintenance organizations.

j. Licensing advisory organizations.

1.1(4) The fraud bureau confronts the problem of insurance 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.

1.1(5) 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 also is 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.

191—1.2(502,505) Location and contact information. The insurance division is located at 330 East Maple in Des Moines, Polk County, Iowa. The general telephone number for the division is (515)281-5705 or 1-877-955-1212. The division's Web site is www.iid.state.ia.us.

FAIR INFORMATION PRACTICES

The insurance division hereby adopts the rules on fair information practices of the Governor's Task Force on Uniform Rules of Agency Procedure to appear as subrules 1.3(1) to 1.3(8) with amendments. The uniform rules are printed in the first volume of the Iowa Administrative Code.

191—1.3(22,502,505) Public information and inspection of records.

1.3(1) *Definitions.* As used in this chapter:

"Agency" means the insurance division of the department of commerce.

"Confidential records" are records which are not available as a matter of right for examination and copying by members of the public under law. Confidential records include records that the agency is prohibited by law from making available for examination by members of the public, and records that are specified as confidential by Iowa Code section 22.7, or other provisions of law, but that 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.

"Custodian" means the agency or a person lawfully delegated authority by the agency to act for the agency 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 which identifies the individual and which is contained in a record system and does not include information pertaining to corporations.

"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 agency.

"Record system" means any group of records under the control of the agency from which a record may be retrieved by a personal identifier such as the name of the individual, number, symbol or other unique retriever assigned to the individual.

1.3(3) *Requests for access to records.*

a. Location of record. A request for access to a record should be directed to the office of the bureau where the record is kept. If the location of the record is not known by the requester, the request shall be directed to the division's receptionist at (515)281-5705 or toll-free at 1-877-955-1212, or in writing

to Iowa Insurance Division, 330 East Maple, Des Moines, Iowa 50319-0065. The division will forward the request to the appropriate person.

b. Office hours. Records shall be made available from 8 a.m. to 4 p.m. daily, excluding Saturdays, Sundays and legal holidays.

c. Telephone access. The general telephone number for the insurance division is (515)281-5705 or toll-free at 1-877-955-1212.

d. Internet access. The division's Internet Web site home page is www.iid.state.ia.us. The page from which the division's bulletins are available is http://www.iid.state.ia.us/news_media/bulletins.asp.

e. Request for access. Requests for access to open records may be made in writing, in person, or by telephone. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

f. Response to requests. The division provides a public access room with photocopiers and work surfaces. Space is limited and advance reservations are requested. A location will be made available as soon as feasible. Subject to availability of the public access room or an alternative location in the division's offices, 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 shall comply with the request as soon as feasible. 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), or to permit the division time to redact personally identifiable information from the record. The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing. The division may deny access to the record by members of the public only on the grounds that such denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order.

g. Fees. Copies of an open record may be made in the division's public access room. Price schedules for published materials and for photocopies of records shall be determined by the division and prominently posted in the public access room. The payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest. When the mailing of copies of records is requested, the actual costs of the mailing will be charged to the requester.

The following additional subrules are also adopted:

1.3(9) *Data processing system.* The agency currently has certain data processing systems which match, collate or permit the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

1.3(10) *Agency records routinely available for public inspection.* The agency collects and maintains the following records that are open records, some of which may contain personally identifiable information:

a. Financial statements of insurers.

b. Rate and policy form filings by insurers.

c. The records of rule making, declaratory ruling, and contested case proceedings.

d. Agent licensure records.

e. The records of premium tax and fee collection.

f. Insurer acquisition and reinsurance records.

g. Securities issuer registration records, exemption filings, and agent or broker-dealer records, except those pertaining to a broker-dealer audit or investigation, unless released by the division at a hearing upon the broker-dealer's registration.

h. License, permit, registration, exemption, or other required filings in connection with membership sales, business opportunity promotions, residential service contracts, loan brokers, and motor vehicle service contracts.

i. Various legal and technical publications related to insurance.

j. All other records that are not confidential records under subrule 1.3(11).

1.3(11) *Records which are confidential records.* Confidential agency records are the following:

a. Trade secrets recognized and protected by law. Iowa Code section 22.7(3).

b. Records that represent and constitute the work product of an attorney, which are related to litigation or claim made by or against a public body. Iowa Code section 22.7(4).

c. Reports made to the agency which, if released, would give advantage to competitors and serve no public purpose. Iowa Code section 22.7(6). Included in this category are insurer examination reports prior to expiration of the 20-day period set forth in rule 191—5.1(507) for requesting a hearing before the commissioner of insurance upon the report and if a hearing is requested, until the commissioner enters a decision upon the report, and reports of the National Association of Insurance Commissioners' Insurance Regulatory Information System.

d. Personal information in confidential personnel records of the division. Iowa Code section 22.7(10).

e. Communications not required by law, rule, or procedure that are made to a government body or to any of its employees by identified persons outside of government, to the extent that the government body receiving those communications could reasonably believe that those persons would be discouraged from making them to the government body if they were available for general public examination. Notwithstanding this provision:

(1) The communication is a public record to the extent the person outside of government making that communication consents to its treatment as a public record.

(2) Information contained in the communication is a public record to the extent it can be disclosed without directly or indirectly indicating the identity of the person outside of government making it or enabling others to ascertain the identity of that person.

(3) Information contained in the communication is a public record to the extent it indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act, except to the extent its disclosure would plainly and seriously jeopardize a continuing investigation or pose a clear and present danger to the safety of any person. In any action challenging the failure of the lawful custodian to disclose any particular information of the kind enumerated in this paragraph, the burden of proof is on the lawful custodian to demonstrate that the disclosure of that information would jeopardize an investigation or would pose a clear and present danger. Iowa Code section 22.7(18).

f. Complaint files, investigation files, other investigative reports and other investigative information of the agency relating to discipline of licensed insurance agents, except as allowed under Iowa Code section 505.8(6), 505.17, 507A.10, or 507B.3.

g. Insurance holding company system registration and holding company examination records unless the statutory determination in favor of publication is made. Iowa Code section 521A.7.

h. Reports and recommendations by insurer guaranty associations regarding insolvent or impaired insurers. Iowa Code sections 508C.12(3), 508C.12(5), 515B.10(2).

i. Investigation material in the possession of the superintendent of securities pertaining to violation of the securities laws unless released by the superintendent pursuant to statute. Iowa Code section 502.603(1)*"c."*

j. All records relating to prearranged funeral contracts except upon the approval of the commissioner of insurance or the attorney general. Iowa Code section 523A.2(1)*"e."*

k. Any other records made confidential by law.

191—1.4(505) Service of process. A party to a proceeding who requests that the commissioner provide service of process as allowed by law shall pay a fee to the Iowa insurance division of $50.

These rules are intended to implement Iowa Code sections 22.11, 505.1 and 505.29.

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CHAPTER 2
DECLARATORY ORDERS
[Prior to 2/11/87, see 191—2.6]

191—2.1(17A) Petition for declaratory order.

2.1(1) Any person or agency may file a petition with the insurance 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, at the address disclosed in rule 191—1.2(502,505). A petition is deemed filed when it is received. The division shall provide petitioner with a file-stamped copy of the petition if petitioner provides the agency an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE INSURANCE DIVISION OF THE STATE OF IOWA

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

2.1(2) The petition shall provide the following information:

a. A clear and concise statement of all relevant facts upon which the order is requested.

b. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability or interpretation is questioned, and any other relevant law.

c. The questions petitioner wants answered, stated clearly and concisely.

d. The answers to the questions desired by petitioner and a summary of the reasons urged by petitioner in support of those answers.

e. The reasons for requesting the declaratory order and disclosure of petitioner's interest in the outcome.

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

g. Any request by petitioner for a meeting provided for by rule 2.7(17A).

The petition must be dated and signed by petitioner or petitioner's representative. It must also include the name, mailing address, and telephone number of petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

191—2.2(17A) Notice of petition. Within seven days after receipt of a petition for a declaratory order, the insurance division shall give notice of the petition to all persons not served by petitioner pursuant to rule 2.6(17A) to whom notice is required by any provision of law. The division may also give notice to any other persons.

191—2.3(17A) Intervention. A person may file a petition for intervention at any time prior to issuance of an order and may be allowed to intervene in a proceeding for a declaratory order at the discretion of the insurance division.

191—2.4(17A) Briefs. Petitioner or any intervenor shall file a brief in support of the position urged.

191—2.5(17A) Inquiries. Inquiries concerning the status of a declaratory proceeding may be made to the insurance division at the address disclosed in rule 191—1.2(502,505).

191—2.6(17A) Service and filing of petitions and other papers.

2.6(1) 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. The party filing a document is responsible for service.

2.6(2) All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the insurance division at the address disclosed in rule 191—1.2(502,505). All petitions, briefs, or other papers required to be served upon a party shall be filed simultaneously with the division.

2.6(3) Method of service, time of filing, and proof of mailing shall be as provided by rule 3.12(17A).

191—2.7(17A) Consideration. Upon request by petitioner, the insurance division must schedule a brief and informal meeting between the original petitioner, all intervenors, and the commissioner or a member of the commissioner's staff, to discuss the questions raised.

191—2.8(17A) Action on petition.

2.8(1) Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receiving a petition for a declaratory order, the insurance division shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

2.8(2) The date of issuance of an order is as defined in rule 3.2(17A).

191—2.9(17A) Refusal to issue order.

2.9(1) The insurance division shall not issue a declaratory order where prohibited by 1998 Iowa Acts, chapter 1202, section 13(1), and may refuse to issue a declaratory order on some or all questions raised for 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 petitioner will be aggrieved or adversely affected by failure of the division to issue an order.

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

d. The questions presented by the petition are also presented in a current rule making, 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 an agency 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 petitioner.

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

2.9(2) A refusal to issue a declaratory order must indicate the specific grounds for refusal and constitutes final agency action on the petition.

2.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude filing of a new petition that seeks to eliminate the grounds for refusal to issue a ruling.

191—2.10(17A) Contents of declaratory order—effective date. In addition to the ruling itself, a declaratory order must contain the date of its issuance, the name of 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.

A declaratory order is effective on the date of issuance.

191—2.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

191—2.12(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 insurance division, petitioner, and any intervenors 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.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

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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.

191—3.2(17A) Definitions. Except where otherwise specifically defined by law or the context otherwise requires:

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

"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 1998 Iowa Acts, chapter 1202, section 14.

"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.

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

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

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

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.

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 agency action in question. The request shall be filed with the insurance division, at the address disclosed in rule 191—1.2(502,505).

The request for a contested case proceeding shall state the name and address of the requester, identify the specific agency action which is disputed 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, and shall include a short and plain statement of the issues of material fact in dispute.

191—3.5(17A) Commencement of hearing; notice.

3.5(1) Delivery of the notice of hearing constitutes commencement of the contested case proceeding. Delivery shall be accomplished in the manner described below, at least 15 days before the hearing date unless the parties agree to a shorter time period, or unless otherwise provided by statute.

a. For nonlicensed persons, delivery may be accomplished by:

(1) Personal service as provided in the Iowa Rules of Civil Procedure; or

(2) Certified mail, return receipt requested; or

(3) First-class mail; or

(4) Publication, as provided in the Iowa Rules of Civil Procedure.

b. For licensees, delivery shall be executed by:

(1) Personal service as provided in the Iowa Rules of Civil Procedure; or

(2) Restricted certified mail.

3.5(2) The notice of hearing shall be prepared in the form of an order and contain the following information:

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 insurance 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 informal settlement;

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

i. Notification of the time period in which a party may request, under 1998 Iowa Acts, chapter 1202, section 15(1), and rule 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.

3.5(3) 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.

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. 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 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.

3.5(4) 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 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) The hearing in a contested case proceeding shall be held within 90 days after the date of the notice of hearing, subject to the provisions of rule 3.17(17A).

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 and appeals must file a written request with the insurance division within 20 days after service of a notice of hearing identifying or describing the presiding officer as the commissioner or members of the commissioner's staff.

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 chapters 507A, 507B, 508B, 515G and 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 provided otherwise 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.

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 insurance division may exercise discretion to refuse to give effect to such a waiver when the waiver is to be inconsistent with the public interest.

191—3.8(17A) Telephone proceedings.

3.8(1) The presiding officer may resolve preliminary procedural motions by telephone conference 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 or other electronic means in which all parties have an opportunity to participate. Any party may call witnesses by telephone, 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.

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 case, the specific controversy underlying that 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 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 as amended by 1998 Iowa Acts, chapter 1202, section 19, and subrules 3.9(3) and 3.23(9).

3.9(3) In a situation where a presiding officer or other person 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.

3.9(4) To request disqualification of a presiding officer, a party shall file a motion supported by an affidavit pursuant to 1998 Iowa Acts, chapter 1202, section 19(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 3.25(17A) and seek a stay under rule 3.29(17A).

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.

191—3.11(17A) Pleadings.

3.11(1) Petition for intervention requirements:

a. Any petition required in a contested case proceeding shall be filed within 20 days of delivery of the notice of hearing or subsequent order of the presiding officer, unless otherwise ordered.

b. A petition shall state in separately numbered paragraphs the following:

(1) The persons or entities on whose behalf the petition is filed;

(2) The particular provisions of statutes and rules involved;

(3) The relief demanded and the facts and law relied upon for such relief; and

(4) The name, address and telephone number of petitioner and petitioner's attorney, if any.

3.11(2) An answer to a petition for intervention shall be filed within 20 days of service of the petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement 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 pleading 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.

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 petition 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.

3.11(3) Any petition for intervention may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and 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.

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

3.12(1) Every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery 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 insurance division, at the time of filing. 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) Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivering or mailing a copy to the attorney at the attorney's last-known address. Service upon an unrepresented party shall be made by delivering or mailing a copy to the party's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

3.12(3) After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the presiding officer.

3.12(4) Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the presiding officer, 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.

3.12(5) 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 Insurance Division at the address disclosed in 191—1.2(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).
>
> (Date) (Signature)

3.12(6) The presiding officer, by order, may permit service or filing of particular documents by facsimile or electronic mail or similar electronic means unless such service or filing is precluded by a provision of law. When permitted, service by facsimile, electronic mail or similar electronic means is complete upon transmission. In the absence of such an order, facsimile or electronic transmission does not satisfy service or filing requirements, but may be used to supplement service or filing when rapid notice is needed.

191—3.13(17A) Discovery.

3.13(1) Where statutory time limitations permit, discovery may be conducted as permitted by the Iowa Rules of Civil Procedure. 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.

3.13(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

3.13(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

191—3.14(17A) Subpoenas.

3.14(1) A subpoena shall be issued by the presiding officer at a party's request. Such a request must be in writing. 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 hearing. The request shall include the name, address, and telephone number of the requesting party.

3.14(2) 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.

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.

191—3.15(17A) Motions.

3.15(1) No technical form for motions is required. However, prehearing motions must be in writing, 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, 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 237 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, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. 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 3.28(17A) and appeal pursuant to rule 3.27(17A).

191—3.16(17A) Prehearing conference.

3.16(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 14 days prior to the hearing date. A prehearing conference shall be scheduled not less than three 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 shall be conducted by telephone unless otherwise ordered.

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 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 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. 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 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.

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.

191—3.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing.

191—3.19(17A) 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. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

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.

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 or the court reporter, 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 or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, or duly authorized agent. Any party may be represented by an attorney or another person authorized by law, subject to Iowa Court Rule 113.

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 which 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.

191—3.21(17A) 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.

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, 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 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 3.27(17A). 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.

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) 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.

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 236.

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 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 consistent with the request for relief made in the petition, notice of hearing, or charging document and embraced in its issues.

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 3.29(17A).

191—3.23(17A) Ex parte communication.

3.23(1) 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 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) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

3.23(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 3.12(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification.

3.23(5) 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(6) 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 3.16(17A).

3.23(7) 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(8) 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.

3.23(9) 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, suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by agency personnel shall be reported to the first deputy commissioner or designee for possible sanctions including censure, suspension, dismissal or other disciplinary action.

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.

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.

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 agency without further proceedings unless there is an appeal to, or review on motion of, the commissioner within the time provided in rule 3.27(17A).

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 unless there is an appeal to, or review on motion of, the commissioner within the time provided in rule 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.

191—3.27(17A) Appeals and review.

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 insurance 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.

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 agency 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 applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the division shall serve copies 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.

191—3.29(17A) Stay of agency action.

3.29(1) Petition requirements for stay of agency 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 agency. 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 1998 Iowa Acts, chapter 1202, section 23(5c).

3.29(3) A stay may be vacated by the issuing authority upon application of the commissioner or any other party.

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.

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 insurance division may issue a written order in compliance with 1998 Iowa Acts, chapter 1202, section 21, 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 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;

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 insurance 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 one or more of the following procedures:

(1) For nonlicensed persons, delivery may be executed by:

1. Personal service as provided in the Iowa Rules of Civil Procedure; or
2. Certified mail, return receipt requested; or
3. First-class mail; or
4. Publication, as provided in the Iowa Rules of Civil Procedure; or
5. Facsimile or other electronic transmission. Facsimile or other electronic transmission may be used as the sole method of delivery if the person required to comply with the order has filed a written request that agency orders be sent by facsimile and has provided a fax number for that purpose.

(2) For licensees, delivery shall be executed by:

1. Personal service a provided in the Iowa Rules of Civil Procedure; or
2. Restricted certified mail.

b. If practical, the insurance 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 insurance 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 insurance 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 insurance 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.17, 523B.8(1), 523D.13, and 523E.17; chapters 505, 507B, 507C, 508, and 515; and rule 191—3.32(502,505).

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.

191—3.33(17A,502,505) Informal settlement.

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

a. Parties desiring informal settlement shall set forth in writing the various points of a proposed settlement, which may include a stipulated statement of facts.

b. When signed by the parties to a controversy, a proposed settlement shall represent final disposition of the matter in place of contested case proceedings.

c. Where there are more than two parties to a controversy involving the insurance division, a separate settlement between one party and the division is permissible.

d. A proposed settlement which is not accepted or signed by the parties shall not be admitted as evidence in the record of a contested case proceeding.

3.33(2) A party to a contested case proceeding may attempt informal settlement by complying with the procedures set forth in this subrule. No party shall be required to settle the contested case proceeding by submitting to informal settlement procedures.

a. Parties desiring informal settlement shall set forth in writing the various points of a proposed settlement, which may include a stipulated statement of facts.

b. When signed by the parties to the contested case proceeding and the presiding officer, a proposed settlement shall represent final disposition of the proceeding.

c. Where there are more than two parties to a contested case proceeding involving the insurance division, a separate settlement between one party and the division is permissible.

d. A proposed settlement which is not accepted or signed by the parties and the presiding officer 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.

191—3.34(17A,502,505) Witness fees.

3.34(1) Subpoenaed witnesses shall be entitled to receive fees authorized by Iowa Code section 622.69.

3.34(2) 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.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

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CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING AND WAIVER OF RULES

DIVISION I
AGENCY PROCEDURE FOR RULE MAKING

191—4.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules adopted by the insurance division are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

191—4.2(17A) Advice on possible rules before notice of proposed rule adoption. In addition to seeking information by other methods, the insurance division may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1)*"a,"* solicit comments from the public on a subject matter of possible rule making by causing notice to be published in the Iowa Administrative Bulletin and indicating where, when, and how persons may comment.

191—4.3(17A) Public rule-making docket.

4.3(1) The insurance division shall maintain a current public rule-making docket.

4.3(2) The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced by publication in the Iowa Administrative Bulletin to the time it is terminated or the rule becomes effective. For each rule-making proceeding, the docket shall indicate:

a. The subject matter of the proposed rule;

b. A citation to all published notices relating to the proceeding;

c. Where written submissions on the proposed rule may be inspected;

d. The time during which written submissions may be made;

e. The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected and where and when oral presentations may be made;

f. Whether a written request for issuance of a regulatory analysis or a concise statement of reasons has been filed, whether such an analysis or statement or a fiscal impact statement has been issued, and where any such written request, analysis or statement may be inspected;

g. The current status of the proposed rule;

h. Any known timetable for division decisions or other action in the proceeding;

i. The date of the rule's adoption;

j. The date of the rule's filing and publication;

k. The date on which the rule will become effective; and

l. Where the rule-making record may be inspected.

191—4.4(17A) Notice of proposed rule making.

4.4(1) At least 35 days before adoption of a rule the insurance division shall publish Notice of Intended Action in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

a. A brief explanation of the purpose of the proposed rule;

b. The specific legal authority for the proposed rule;

c. Except to the extent impracticable, the text of the proposed rule;

d. Where, when, and how persons may present their views on the proposed rule; and

e. Where, when, and how persons may request an oral proceeding on the proposed rule if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impractical, the insurance division shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by that omitted text of the proposed rule, and the range of possible choices being considered by the division for the resolution of each of those issues.

4.4(2) A proposed rule may incorporate other materials by reference only if it complies with subrule 4.12(2).

4.4(3) Persons desiring copies of future Notices of Intended Action by subscription must file with the insurance division at the address disclosed in rule 191—1.2(502,505) a written request indicating the name and address to which such Notices of Intended Action should be sent. The request shall specify whether the person wants to receive insurance rules, securities bureau rules as defined by rule 191—1.1(502,505), or both. Within seven days after submission of a Notice of Intended Action for publication, the division shall mail or otherwise transmit a copy of that notice to subscribers who have filed a written request. The written request shall be accompanied by payment of the subscription price. The subscription price per calendar year is $15 for securities rules only, $15 for insurance rules only, and $30 for both.

191—4.5(17A) Public participation.

4.5(1) For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data and views, in writing, on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to the insurance division or the person designated in the Notice of Intended Action, at the address disclosed in rule 191—1.2(502,505).

4.5(2) The insurance division may, at any time, schedule an oral proceeding on a proposed rule. The division shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the division by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following:

a. A request by one or more individual persons must be signed by each person and include the address and telephone number of each person;

b. A request by an association must be signed by an officer or designee of the association and must contain a statement that the association has at least 25 members and the address and telephone number of the person signing that request; and

c. A request by an agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing that request.

4.5(3) This rule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)*"b"* as amended by 1998 Iowa Acts, chapter 1202, section 8, or this chapter.

a. An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

b. The commissioner, or another person designated by the commissioner who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule.

4.5(4) At an oral proceeding on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the insurance division at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

a. At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the agency decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To

encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own.

b. Persons making oral presentations are encouraged to avoid restating matters which have already been submitted in writing.

c. To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

d. The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

e. Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the insurance division.

f. The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

g. Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

h. The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

4.5(5) In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the insurance division may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

4.5(6) The insurance division shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the division at (515)281-5705 in advance to arrange access or other needed services. Persons who are hearing impaired should call Relay Iowa TTY at 1-800-735-2942.

191—4.6(17A) Regulatory analysis.

4.6(1) A "small business" is defined in 1998 Iowa Acts, chapter 1202, section 10(7).

4.6(2) Small businesses or organizations of small businesses may be registered on the insurance division's small business impact list by making a written application to the division at the address disclosed in rule 191—1.2(502,505). The application for registration shall state:

a. The name of the small business or organization of small businesses;

b. Its address;

c. The name of a person authorized to transact business for the applicant;

d. A description of the applicant's business or organization; an organization representing 25 or more persons who each qualify as a small business shall indicate that fact; and

e. Whether the applicant desires copies of Notices of Intended Action, for a reasonable cost, or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

The insurance division may at any time request additional information from the applicant to determine whether the applicant is qualified as a small business or as an organization of 25 or more small businesses. The division may periodically send a letter to each registered small business or organization, or organization of small businesses, asking whether that business or organization wishes to remain on the registration list. The name of a small business or organization of small businesses will be removed from the list if a negative response is received, or if no response is received within 30 days after the letter is sent.

4.6(3) Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the insurance division shall mail to all registered small businesses or organizations of small businesses, in accordance with their request, either a copy of the Notice of Intended Action or notice of the subject of that proposed rule making. For a rule that may have an impact on small business adopted in reliance upon Iowa Code section 17A.4(2), the

division shall mail notice of the adopted rule to registered businesses or organizations prior to the time the adopted rule is published in the Iowa Administrative Bulletin.

4.6(4) The insurance division shall issue a regulatory analysis of a proposed rule that conforms to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2a), after a proper request from:

a. The administrative rules review committee; or

b. The administrative rules coordinator.

4.6(5) The insurance division shall issue a regulatory analysis of a proposed rule that conforms to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2b), after a proper request from:

a. The administrative rules review committee;

b. The administrative rules coordinator;

c. At least 25 or more persons who sign the request provided that each represents a different small business; or

d. An organization representing at least 25 small businesses. The request shall list the name, address and telephone number of not less than 25 small businesses it represents.

4.6(6) Upon receipt of a timely request for a regulatory analysis the insurance division shall adhere to the time lines described in 1998 Iowa Acts, chapter 1202, section 10(4).

4.6(7) A request for a regulatory analysis is made when it is received by the division, at the address disclosed in rule 191—2.1(502,505). The request shall be in writing and satisfy the requirements of 1998 Iowa Acts, chapter 1202, section 10(1).

4.6(8) The contents of the concise summary shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(4,5).

4.6(9) Upon request, the insurance division shall make available to the extent feasible, copies of the published summary in conformance with 1998 Iowa Acts, chapter 1202, section 10(5).

4.6(10) When a regulatory analysis is issued in response to a written request from the administrative rules review committee or the administrative rules coordinator, the regulatory analysis shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2a), unless a written request expressly waives one or more of the items listed in that section.

4.6(11) When a regulatory analysis is issued in response to a written request from the administrative rules review committee, the administrative rules coordinator, at least 25 persons signing that request who each qualify as a small business or by an organization representing at least 25 small businesses, and, if the insurance division determines that the rule would have a substantial impact on small businesses, the regulatory analysis shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2b).

191—4.7(17A,25B) Fiscal impact statement.

4.7(1) A proposed rule that mandates additional combined expenditures exceeding $100,000 by all affected political subdivisions or agencies and entities which contract with political subdivisions to provide services must be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement must satisfy the requirements of Iowa Code section 25B.6.

4.7(2) If the insurance division determines at the time it adopts a rule that the fiscal impact statement upon which the rule is based contains errors, the division shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

191—4.8(17A) Time and manner of rule adoption.

4.8(1) The insurance division shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the insurance division shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication in the Iowa Administrative Bulletin.

4.8(2) Before the adoption of a rule, the insurance division shall fully consider all of the written and oral submissions received in that rule-making proceeding and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

4.8(3) Except as otherwise provided by law, the insurance division may use its own experience, technical competence, specialized knowledge and judgment in the adoption of a rule.

191—4.9(17A) Variance between adopted rule and rule proposed in Notice of Intended Action. The insurance division shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action upon which the rule is based unless:

1. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and
2. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto.

191—4.10(17A) Exemptions from public rule-making procedures.

4.10(1) To the extent the insurance division for good cause finds that public notice and participation are unnecessary, impracticable or contrary to the public interest in the process of adopting a particular rule, the division may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The division shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

4.10(2) The insurance division may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule it adopts in reliance upon subrule 4.10(1).

191—4.11(17A) Concise statement of reasons.

4.11(1) When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the insurance division shall issue a concise statement of reasons for the rule. Requests for such a statement shall be in writing and shall be delivered to the division at the address disclosed in rule 191—1.2(502,505). The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

4.11(2) The concise statement of reasons shall contain:

a. The reasons for adopting the rule;

b. An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change; and

c. The principal reasons urged in the rule-making proceeding for and against the rule, and the insurance division's reasons for overruling the arguments made against the rule.

4.11(3) After a proper request, the insurance division shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request.

191—4.12(17A) Contents, style, and form of rule.

4.12(1) Each rule adopted by the insurance division shall contain the text of the rule and:

a. The date the division adopted the rule;

b. A brief explanation of the principal reasons for the rule-making action;

c. A reference to all rules repealed, amended, or suspended by the rule;

d. A reference to the specific statutory or other authority authorizing adoption of the rule;

e. Any findings required by any provision of law as a prerequisite to adoption or effectiveness of the rule;

f. A brief explanation of the principal reasons for failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waiver or special exceptions provided in the rule if such reasons are required by 1998 Iowa Acts, chapter 1202, section 8, or the insurance division exercises discretion to include such reasons; and

g. The effective date of the rule.

4.12(2) The insurance division may incorporate by reference in a proposed or adopted rule, and without causing publication of the incorporated matter in full, all or any part of a code, standard, rule, or other matter if the division finds that the incorporation of its text in the proposed or adopted rule would be unduly cumbersome, expensive, or otherwise burdensome. The reference in the proposed or adopted rule shall fully and precisely identify the incorporated matter by location, title, citation, date, and edition, if any, and shall briefly indicate the precise subject and the general contents of the incorporated matter. The division may incorporate such matter by reference in a proposed or adopted rule only if the division makes copies of it readily available to the public. The proposed or adopted rule shall state how and where copies of the incorporated matter may be obtained at a reasonable cost from the division. The division shall retain permanently a copy of any materials incorporated by reference in a rule.

If the division adopts standards by reference to another publication, it shall provide a copy of the publication containing the standards to the administrative rules coordinator for deposit in the state law library and may make the standards available electronically.

4.12(3) When the administrative code editor omits the full text of a proposed or adopted rule, the insurance division shall prepare and submit to the administrative code editor a summary statement describing the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules, and of significant issues involved in these rules. The summary statement shall also describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter and any matter incorporated by reference, may be obtained from the division. The division shall provide a copy of that full text for a reasonable charge upon request, shall make copies of the full text available for review at the state law library, and may make the standards available electronically.

4.12(4) In preparing its rules, the division shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

191—4.13(17A) Agency rule-making record.

4.13(1) The insurance division shall maintain an official rule-making record for each rule proposed or adopted. The rule-making record and materials incorporated by reference must be available for public inspection.

4.13(2) The rule-making record shall contain:

a. Copies of all relevant publications in the Iowa Administrative Bulletin and any file-stamped copies of insurance division submissions to the administrative rules coordinator;

b. Copies of any relevant portions of the insurance division's public rule-making docket;

c. All written petitions, requests, and submissions received by the insurance division, and all other written materials of a factual nature as distinguished from opinion that are relevant to the merits of the rule and that were created or compiled by the division and considered by the division, in connection with the formulation, proposal, or adoption of the rule or the proceeding upon which the rule is based, except to the extent the division is authorized by law to keep them confidential; provided, however, that when any such materials are deleted because they are authorized by law to be kept confidential, the division shall identify in the record the particular materials deleted and state the reasons for deletion;

d. Any official transcript of oral presentations made in the proceeding upon which the rule is based or, if not transcribed, the stenographic record or electronic recording of those presentations, and any memorandum prepared by a presiding officer summarizing the contents of those presentations;

e. A copy of any regulatory analysis or fiscal impact statement prepared for the proceeding upon which the rule is based;

f. A copy of the rule and any concise statement of reasons prepared for that rule;

g. All petitions for, amendments of, or repeal or suspension of, the rule;

h. A copy of any objection to the issuance of that rule without public notice and participation that was filed pursuant to Iowa Code section 17A.4(2) by the administrative rules review committee, the governor, or the attorney general;

i. A copy of any objection to the rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(4), and any insurance division response to that objection;

j. A copy of any significant written criticism of the rule, including a summary of any petition for waiver of the rule; and

k. A copy of any executive order concerning the rule.

4.13(3) Except as otherwise required by a provision of law, the rule-making record required by this rule need not constitute the exclusive basis for agency action on that rule.

4.13(4) The insurance division shall maintain the rule-making record for a period of not less than five years from the later of: (a) the date the rule to which it pertains became effective, (b) the date of the Notice of Intended Action, or (c) the date of any written criticism as described in paragraph 4.13(2)*"g," "h," "i,"* or *"j."*

191—4.14(17A) Filing of rules. The insurance division shall file each rule it adopts with the administrative rules coordinator. The filing must be executed as soon after adopting the rule as is practicable. At the time of filing, each rule must have attached to it any fiscal impact statement and any concise statement of reasons that was issued for that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until after the filing of that rule, the note or statement must be attached to the filed rule within five working days after the note or statement is issued. In filing a rule, the division shall use the standard form prescribed by the administrative rules coordinator.

191—4.15(17A) Effectiveness of rules prior to publication.

4.15(1) The insurance division may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if the division finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The division shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

4.15(2) When the insurance division makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3), the division shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule's indexing and publication. The term "all reasonable efforts" requires the division to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the division of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any of the following means: radio, newspaper, television, signs, mail, telephone, personal notice or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of this subrule.

191—4.16(17A) General statements of policy.

4.16(1) The insurance division shall maintain an official, current, and dated compilation that is indexed by subject, containing all of its general statements of policy within the scope of Iowa Code section 17A.2(10)*"a," "c," "f," "g," "h,"* and *"k."* Each addition to, change in, or deletion from the official compilation must also be dated, indexed, and a record thereof kept. Except for those portions containing rules governed by Iowa Code section 17A.2(10)*"f,"* or otherwise authorized by law to be kept confidential, the compilation must be made available for public inspection and copying.

4.16(2) A general statement of policy subject to the requirements of this subsection shall not be relied on by the insurance division to the detriment of any person who does not have actual, timely knowledge

of the contents of the statement until the requirements of subrule 4.16(1) are satisfied. This provision is inapplicable to the extent necessary to avoid imminent peril to the public health, safety or welfare.

191—4.17(17A) Review of rules by division.

4.17(1) Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the insurance division to conduct a formal review of an existing rule. Upon approval of that request by the administrative rules coordinator, the division shall conduct a formal review of a specified rule to determine whether a new rule should be adopted or whether the rule should be amended or repealed. The division may refuse to conduct a review if it has conducted such a review of the specified rule within five years prior to the filing of the written request.

4.17(2) In conducting the formal review, the insurance division shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report shall comply with Iowa Code section 17A.7(2). A copy of the division's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report shall also be available for public inspection at the division at the address disclosed in rule 191—1.2(502,505).

191—4.18(17A) Petition for rule making.

4.18(1) Any person or agency may file a petition for rule making with the insurance division at the address disclosed in rule 191—1.2(502,505). A petition is deemed filed when it is received. The division must provide petitioner with a file-stamped copy of the petition if petitioner provides the 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:

BEFORE THE INSURANCE DIVISION OF THE STATE OF IOWA

Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	}	PETITION FOR RULE MAKING

4.18(2) The petition shall provide the following information:

a. A statement of the specific rule-making action sought by petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation to the particular portion or portions of the rule proposed to be amended or repealed.

b. A citation to any law deemed relevant to the insurance division's authority to take the action urged or to the desirability of that action.

c. A brief summary of petitioner's arguments in support of the action urged in the petition.

d. A brief summary of any data supporting the action urged in the petition.

e. The names and addresses of other persons, or a description of any class of persons known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

f. Any request by petitioner for a meeting provided for by subrule 4.18(7).

4.18(3) The petition must be dated and signed by petitioner or petitioner's representative. It must also include the name, mailing address, and telephone number of petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

4.18(4) The insurance division may deny a petition because it does not substantially conform to the required form.

4.18(5) Petitioner may submit a brief in support of the action urged in the petition. The insurance division may request a brief from petitioner or from any other person concerning the substance of the petition.

4.18(6) Inquiries concerning the status of a rule-making petition may be made to the insurance division at the address disclosed in rule 191—1.2(502,505).

4.18(7) Within 14 days after the filing of a petition, the insurance division must submit a copy of the petition and any accompanying brief to the administrative rules coordinator and to the administrative rules review committee. Upon request by petitioner in the petition, the division must schedule a brief and informal meeting between the petitioner and the division or a member of the division staff, to discuss the petition. The division may request petitioner to submit additional information or argument concerning the petition.

4.18(8) Within 60 days after filing the petition, or within any longer period agreed to by petitioner, the insurance division must, in writing, deny the petition, and notify petitioner of its action and the specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed notified of the denial or grant of the petition on the date when the agency mails or delivers the required notification to petitioner.

4.18(9) Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the insurance division's rejection of the petition.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

191—4.19 and **4.20** Reserved.

DIVISION II
WAIVER AND VARIANCE RULES

191—4.21(17A) Definition. For purposes of Division II of Chapter 4, a "waiver or variance" means action by the insurance division which 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. For simplicity, the term "waiver" shall include both a "waiver" and a "variance."

191—4.22(17A) Scope. Division II of Chapter 4 outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the insurance division in situations when no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede the rules in this division with respect to any waiver from that rule.

Division II of Chapter 4 shall not preclude the division from granting waivers or variances 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.

191—4.23(17A) Applicability of Division II of Chapter 4. The insurance 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 insurance division may not waive the following categories of rules:

1. Rules setting requirements that are created or duties that are imposed by statute.
2. Rules that provide definitions or interpretations, set fees, clarify enforcement authority, deal with fraud or are the subject of prosecutorial discretion.
3. 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 its definition.

191—4.24(17A) Criteria for waiver or variance. In response to a petition completed pursuant to rule 4.26(17A), the insurance 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:

1. Application of the rule would impose an undue hardship on the person for whom the waiver is requested;
2. Waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

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

4. 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; and

5. If the rule implements Iowa Code chapter 502, or is being applied in conjunction with implementation of Iowa Code chapter 502, a waiver may be granted only if the waiver is necessary or appropriate in the public interest or for the protection of investors and consistent with the purposes fairly intended by the policy and provisions of Iowa Code chapter 502.

191—4.25(17A) Filing of petition. A petition for a waiver must be submitted in writing to the insurance division as follows:

4.25(1) *Applications.* If the petition relates to an application or license, the petition shall be made in accordance with the filing requirements for the application or license in question.

4.25(2) *Contested cases.* If the petition relates to a pending contested case, the petition shall 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 insurance commissioner, determines that the petition should be referred directly to the commissioner.

4.25(3) *Other.* If the petition does not relate to an application or a pending contested case, the petition may be submitted to the insurance commissioner.

191—4.26(17A) Content of petition. A petition for waiver shall be typewritten or legibly handwritten in ink and include the following information where applicable and known to the petitioner:

1. A caption which substantially conforms to the following example:

BEFORE THE INSURANCE COMMISSIONER OF THE STATE OF IOWA

In the matter of: (name of person requesting waiver or variance)	}	REQUEST FOR WAIVER OF RULE (specify number of rule for which waiver is requested)

2. 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.

3. A description and citation of the specific rule from which a waiver is requested.

4. The specific waiver requested, including the precise scope and duration.

5. The relevant facts that the petitioner believes would justify a waiver under each of the criteria described in rule 4.24(17A). 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 will justify a waiver.

6. A history of any prior contacts between the insurance 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 insurance division within the prior five years.

7. Any information known to the petitioner regarding the insurance division's treatment of similar cases.

8. The name, address and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the granting of a waiver.

9. The name, address and telephone number of any entity or person who would be adversely affected by the granting of a waiver.

10. The name, address and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

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

191—4.27(17A) Additional information. Prior to issuing an order granting or denying a waiver, the insurance 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.

191—4.28(17A) Notice. The insurance division shall acknowledge a petition upon receipt. The division shall 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 insurance division may give notice to other persons. To accomplish this notice provision, the insurance division may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law, and provide a written statement to the division attesting that notice has been provided.

191—4.29(17A) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 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 insurance division so provides by rule or order or is required to do so by statute.

191—4.30(17A) Ruling. An order granting or denying a waiver shall be in writing and shall 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.

4.30(1) *Insurance division discretion.* The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the insurance division, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the division based on the unique, individual circumstances set out in the petition.

4.30(2) *Burden of persuasion.* The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the insurance division should exercise its discretion to grant a waiver from a division rule.

4.30(3) *Narrowly tailored exception.* A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

4.30(4) *Administrative deadlines.* When the rule from which a waiver is sought establishes administrative deadlines, the insurance division shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

4.30(5) *Conditions.* The insurance division may place any condition on a waiver that the division finds desirable to protect the public health, safety, and welfare.

4.30(6) *Time period of waiver.* A waiver shall 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 insurance division, a waiver may be renewed if the division finds that grounds for a waiver continue to exist.

4.30(7) *Time for ruling.* The insurance division shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall 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 insurance division shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

4.30(8) *When deemed denied.* Failure of the insurance 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 insurance division shall remain responsible for issuing an order denying a waiver.

4.30(9) *Service of order.* Within seven days of its issuance, any order issued under this chapter shall 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.

191—4.31(17A) Public availability. All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the insurance division is authorized or required to keep confidential. The division may accordingly redact confidential information from petitions or orders prior to public inspection.

191—4.32(17A) Summary reports. Semiannually, the insurance division shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the division's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

191—4.33(17A) Cancellation of a waiver. A waiver issued by the insurance 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:

1. 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
2. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
3. The subject of the waiver order has failed to comply with all conditions contained in the order; or
4. The waiver is contrary to the public health, safety and welfare in light of newly discovered evidence or changed circumstances.

191—4.34(17A) 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.

191—4.35(17A) Defense. After the insurance division issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

191—4.36(17A) Judicial review. Judicial review of a decision by the insurance division to grant or deny a waiver petition may be sought in accordance with Iowa Code chapter 17A.

These rules are intended to implement Iowa Code section 17A.9A and Executive Order Number 11.

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REGULATION OF INSURERS

CHAPTER 5
REGULATION OF INSURERS—GENERAL PROVISIONS

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

191—5.1(507) Examination reports. Upon the completion of an examination a copy of the report will be furnished the company, association or society examined, whereupon the company, association or society will have 20 days in which to determine whether or not it will demand a hearing before the commissioner of insurance. If a hearing is desired, then and in that event the company, association or society shall, within said 20 days, file with the commissioner of insurance a written application, attaching thereto the specific grounds upon which a hearing is desired. Within a reasonable time after the receipt of said application, the commissioner will fix a date for the hearing and notify the company, association or society thereof. Upon the completion of the hearing, or as soon as convenient thereafter, the commissioner shall render the commissioner's decision, either orally or in writing at the commissioner's discretion and file said report as part of the records in the division.

This rule is intended to implement Iowa Code sections 505.8 and 507.2.

191—5.2(505,507) Examination for admission. Any foreign or alien insurance company seeking to be admitted to do business in the state of Iowa shall, at the discretion of the division of insurance, be subject to either or both of the following:

1. An on-site examination by the division;
2. A desk examination, if the applicant provides a financial examination report prepared by the insurance regulatory body of the applicant's state or country of domicile. The examination report must be certified by the issuing regulatory body and must have an effective date of not more than two years prior to the date of application for admission.

This rule is intended to implement Iowa Code section 507.2.

191—5.3(507,508,515) Submission of quarterly financial information. All insurers, corporations, associations, and other entities required to submit annual financial statements to the commissioner shall also submit a short form quarterly financial statement within 45 days of the close of each calendar quarter on a form as specified by the commissioner. Upon request of the commissioner an exhibit showing a count of policies in force by line of business as of the close of the quarter shall be submitted with the quarterly report. The quarterly financial statements shall also be filed with the National Association of Insurance Commissioners.

This rule is intended to implement Iowa Code section 507.2 and Iowa Code chapters 508 and 515.

191—5.4(505,508,515,520) Surplus notes. Surplus notes are recognized by the commissioner for both stock and mutual insurers. All payments of principal and interest on these notes require the prior approval of the commissioner.

191—5.5(505,515,520) Maximum allowable premium volume. A domestic property/casualty insurer shall not cause the ratio of its net written premiums to its surplus as regards policyholders to exceed three to one without the approval of the commissioner of insurance.

191—5.6(505,515,520) Treatment of various items on the financial statement. An admitted insurer shall at all times show the value of the following items on its financial statements in the following manner unless a different treatment is authorized by the state where the insurer is domiciled:

5.6(1) *Real estate.* At amortized cost.

5.6(2) *Stocks.* At market value as determined by the Securities Valuation Office of the National Association of Insurance Commissioners.

5.6(3) *Bonds.* At amortized cost, unless directed otherwise by the commissioner of insurance.

5.6(4) *Artwork.* Nonadmitted.

5.6(5) *Other assets not listed.* As treated by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.

5.6(6) *Liabilities.* Liabilities, including active life reserves, unearned premium reserves, and liabilities for claims and losses unpaid and for incurred but not reported claims. As determined by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.

These rules are intended to implement Iowa Code sections 505.8, 515.20, 515.49, 515.63, and 520.21.

191—5.7(505) Ordering withdrawal of domestic insurers from states. Upon a finding, after notice and opportunity for hearing, of substantial likelihood of future financial impairment of a domestic insurer due to persistent operating losses in any line of business in any state where the insurer does business, the commissioner may order a domestic insurer to withdraw and cease doing business in that line of business in that state or in the alternative, order the insurer to withdraw and cease doing business in all lines, pending further order. For the purposes of this rule, impaired or threatened financial solvency is deemed to exist where an insurer experiences a reduction of 5 percent or greater in surplus in any 12-month period from all cases, including the regulatory environment in a state.

191—5.8(505) Monitoring. Upon request of the commissioner, a domestic insurer shall provide all relevant information as to its business in any state identified by the commissioner and found by the commissioner to have a consistently oppressive and confiscatory regulatory environment: The commissioner's request shall identify the state and shall include a basis for the commissioner's findings that the state has a consistently oppressive and confiscatory regulatory environment.

191—5.9(505) Rate and form filings. Insurers doing business in Iowa shall file rates and forms in accordance with applicable law and with 191—Chapters 20, 30, 31, 34, 35, 36, 37, and 39, as applicable.

191—5.10(511) Life companies—permissible investments.

5.10(1) The phrase "preferred dividend requirements as of the date of acquisition" in Iowa Code section 511.8(6) is construed to include the dividend requirements of a new issue. Consequently, a new preferred issue will qualify if the net earnings of the corporation for each of the five preceding years have been not less than one and one-half times the sum of the annual fixed charges, contingent interest and the annual preferred dividend requirements including the new issue.

5.10(2) The phrase "the obligations are adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant" in Iowa Code section 511.8(5) means "investment grade" as defined in 191—subrule 22.1(4). As a result, except as permitted by the commissioner in exceptional circumstances, corporate obligations must be "investment grade" in order to meet legal reserve requirements unless the other requirements of Iowa Code section 511.8(5)*"a"* regarding the financial condition of the issuer of the obligation are met. The legal reserve investment limitations of Iowa Code section 511.8 regarding less than investment grade obligations, but not the deposit requirements of that section, are applicable to foreign insurers.

This rule is intended to implement Iowa Code section 511.8(5).

191—5.11(511) Investment of funds.

Ruling No. R21. By Division.

The Forty-first General Assembly of Iowa amended [508 & 511](511.8) of the Code of 1924, relating to the investment of funds by life insurance companies organized in this state, by adding to paragraph one of said section the following:

"Or federal farm loan bonds issued under the Act of Congress, approved July 17, 1916."

Doubt has arisen in the minds of company officials as to whether or not the amendment in question authorizes life insurance companies organized in Iowa to invest their funds in bonds issued by joint stock land banks.

In a written opinion of the attorney general of Iowa, bearing date May 25, 1925, it is held that, inasmuch as joint stock land banks were created under the Act of Congress approved July 17, 1916, bonds issued by such banks are included in the amendment aforesaid.

Therefore, it is the ruling of this division that such bonds are a legal investment for life insurance companies organized in this state. However, said amendment is not effective until July 4, 1925, and until said date no such investments should be made.

191—5.12(515) Collateral loans. The collateral pledged to secure a loan must qualify as a legal investment for insurance companies before the loan it secures may so qualify [section 515.35(7)]. The statute provides that a company may not invest in excess of 30 percent of its capital and funds in stocks and not more than 10 percent of its capital and surplus in the stock or bonds, or both, of any one corporation.

Normally, a loan is little better than the collateral securing it. Therefore, in order to conform to the intent and purpose of the legislature it would appear that the same limitations should likewise be applied to the stock securing a collateral loan. The statute also provides that the value of the collateral must exceed the amount of the loan by 10 percent.

191—5.13(508,515) Loans to officers, directors, employees, etc. No insurance company or association of any kind, domiciled in the state of Iowa, shall loan any portion of its funds to an officer, director, stockholder, employee or any relative or immediate member of the family of an officer or director.

The provisions of Iowa Code sections 508.8 and 511.12 shall likewise be applicable to fire and casualty companies.

191—5.14(515) Salvage as an asset. Rescinded IAB 11/25/92, effective 11/6/92.

191—5.15(508,512B,514,514B,515,520) Accounting practices and procedures manual and annual statement instructions.

5.15(1) *Purpose.* The purpose of this rule is to adopt the National Association of Insurance Commissioners' accounting practices and procedures manual which has ben revised to provide a comprehensive guide to statutory accounting principles, commonly referred to as the "codification project." Additionally, the rule adopts by reference the annual statement instructions promulgated by the National Association of Insurance Commissioners.

5.15(2) *Financial statements.* Effective January 1, 2001, all information reflected in the financial statements of insurance companies authorized to do business in Iowa shall conform with the accounting practices and procedures manual of the National Association of Insurance Commissioners.

All annual financial statements filed with the commissioner shall conform to the annual statement instructions and manuals promulgated by the National Association of Insurance Commissioners.

This rule is intended to implement Iowa Code sections 508.11(43), 512B.24, 514.9, 514B.12, 515.63 and 520.10.

191—5.16 to **5.19** Reserved.

191—5.20(508) Computation of reserves. Iowa life insurance companies may report the nonadmitted excess item to this division on the basis of the true reserve instead of the mean reserve as has been the practice in the past. Under the true reserve system there will be no excess excepting in the case of indebtedness in excess of policy liabilities. The true reserve system eliminates all excess on account of due and deferred premiums, but there may be an excess equal to or in excess of the loading depending upon what premium the note represents, and how long it has been running when a premium note is taken for the gross premiums or when there is an overloan.

This concession is made to Iowa companies with the conviction that it removes many of the defects and disadvantages of the present practice of requiring the excess of the mean reserve.

As a corollary to the proposed system of determining this excess item, the business of the company must be reported upon a strictly paid for basis.

This division will not require that policies be lapsed if premium is not paid within a limited time after the due date, but no credit for an uncollected premium may be taken if more than 60 days past due, unless a premium note of the proper form has been taken therefor.

UNEARNED PREMIUM RESERVES ON MORTGAGE GUARANTY INSURANCE POLICIES

191—5.21(515C) Unearned premium reserve factors. In the case of premiums paid in advance on ten-year policies, mortgage guaranty insurers shall apply the following annual factors or comparable monthly factors in determining the unearned premium reserve:

Years policy is in force	Unearned premium factor	Years policy is in force	Unearned premium factor
1	81.8	6	18.2
2	65.5	7	10.9
3	50.9	8	5.5
4	38.2	9	1.8
5	27.3	10	-0-

191—5.22(515C) Contingency reserve. From the premium remaining after applying the appropriate factor from the table in 5.21(515C) above, there shall be maintained a contingency reserve as prescribed in Iowa Code section 515C.4.

These rules are intended to implement Iowa Code sections 515C.3 and 515C.4.

191—5.23(507C) Standards. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public. The commissioner may consider:

5.23(1) Adverse findings reported in financial condition and market conduct examination reports.

5.23(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports.

5.23(3) The ratios of commission expense, general insurance expense, policy benefits and reserve increases to annual premium and net investment income which could lead to an impairment of capital and surplus.

5.23(4) The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to ensure the company's ability to meet its outstanding obligations as they mature.

5.23(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

5.23(6) The insurer's operating loss in the last 12-month period or any shorter period of time including, but not limited to: net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders reduces such insurer's remaining surplus as regards policyholders below the minimum required.

5.23(7) Whether any affiliate, subsidiary or reinsurer of the insurer is insolvent as defined in Iowa Code section 507C.2(11), is threatened with insolvency, or is delinquent in payment of its monetary or other obligation.

5.23(8) Contingent liabilities, pledges or guarantees which either individually or collectively involve a total amount which, in the opinion of the commissioner, may affect the solvency of the insurer.

5.23(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

5.23(10) The age and collectibility of receivables.

5.23(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position.

5.23(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry.

5.23(13) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

5.23(14) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

5.23(15) Whether the company has experienced or will experience in the foreseeable future cash flow or liquidity problems.

5.23(16) Rescinded IAB 7/10/91, effective 6/21/91.

This rule is intended to implement Iowa Code sections 507C.9, 507C.12 and 507C.17.

191—5.24(507C) Commissioner's authority.

5.24(1) For the purposes of making a determination of an insurer's financial condition under this rule, the commissioner may:

a. Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding;

b. Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

c. Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

d. Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

5.24(2) If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may issue an order requiring the insurer to:

a. Reduce the total amount of present and potential liability for policy benefits by reinsurance;

b. Reduce, suspend or limit the volume of business being accepted or renewed;

c. Reduce general insurance and commission expenses by specified methods;

d. Increase the insurer's capital and surplus;

e. Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

f. File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

g. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

h. Document the adequacy of premium rates in relation to the risks insured;

i. File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the commissioner.

5.24(3) Any insurer subject to an order under subrule 5.24(2) may request, pursuant to rule 191—3.4(17A), review of that order. Any ensuing hearing shall not be open to the public, unless the insurer requests otherwise.

This rule is intended to implement Iowa Code sections 507C.9, 507C.12 and 507C.17.

191—5.25(505) Annual audited financial reports.

5.25(1) *Purpose.* The purpose of this rule is to improve the Iowa insurance division's surveillance of the financial condition of insurers by requiring an annual examination by independent certified public accountants of the financial statements reporting the financial position and the results of operations of insurers.

Every insurer (as defined in subrule 5.25(2), paragraph *"c,"*) shall be subject to this rule. Insurers having direct premiums written in this state of less than $1 million in any calendar year and less than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of such calendar year shall be exempt from this rule for such year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts or treaties of reinsurance of $1 million or more will not be so exempt.

Foreign or alien insurers filing audited financial reports in another state, pursuant to such other state's requirement of audited financial reports which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from this rule if:

a. A copy of the Audited Financial Report, Report on Significant Deficiencies in Internal Controls, and the Accountant's Letter of Qualifications which are filed with such other state are filed with the commissioner in accordance with the filing dates specified in subrules 5.25(3), 5.25(10), and 5.25(11), respectively (Canadian insurers may submit accountants' reports as filed with the Canadian Dominion Department of Insurance).

b. A copy of any Notification of Adverse Financial Condition Report filed with such other state is filed with the commissioner within the time specified in subrule 5.25(9).

This rule shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers under the rules of the division of insurance and the practices and procedures of the division of insurance.

5.25(2) *Definitions.* As used in this rule:

"Audited financial report" means and includes those items specified in subrule 5.25(4).

"Accountant" or *"independent certified public accountant"* means an independent certified public accountant or accounting firm in good standing with the American Institute of CPAs and in all states in which they are licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

"Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

"Insurer" means a licensed insurer under Title XIII of the Iowa Code, except entities organized under Iowa Code chapters 512A, 512B, 518, and 518A.

5.25(3) *Filing and extensions for filing of annual audited financial reports.* All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with 90 days' advance notice to the insurer.

Extensions of the June 1 filing date may be granted by the commissioner for 30-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

5.25(4) *Contents of annual audited financial report.* The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the division of insurance of the state of domicile.

The annual audited financial report shall include the following:

a. Report of independent certified public accountant.

b. Balance sheet reporting admitted assets, liabilities, capital and surplus.

c. Statement of operations.

d. Statement of cash flows.

e. Statement of changes in capital and surplus.

f. Notes to financial statements. These notes shall be those required by the appropriate National Association of Insurance Commissioners (NAIC) annual statement instructions and the NAIC accounting practices and procedures manual. The notes shall include:

(1) A reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Iowa Code sections 508.11 and 515.63 with a written description of the nature of these differences.

(2) A summary of ownership and relationships of the insurer and all affiliated companies.

g. The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.)

5.25(5) *Designation of independent certified public accountant.* Each insurer required by this rule to file an annual audited financial report must, within 60 days after becoming subject to such requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm (generally referred to in this rule as the "accountant") retained to conduct the annual audit set forth in this rule. Insurers not retaining an independent certified public accountant on August 28, 1991, shall register the name and address of their retained certified public accountant not less than six months before the date when the first audited financial report is to be filed.

The insurer shall obtain a letter from the accountant, and file a copy with the commissioner, stating that the accountant is aware of the provisions of Title XIII of the Iowa Code and administrative rules thereunder that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the insurance division, specifying such exceptions as the accountant may believe appropriate.

If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five business days notify the division of this event. The insurer shall also furnish the commissioner with a separate letter within ten business days of the above notification stating whether in the 24 months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this rule include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this rule are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request such former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

5.25(6) *Qualifications of independent certified public accountant.*

a. The commissioner shall not recognize any person or firm as a qualified independent certified public accountant that:

(1) Is not in good standing with the American Institute of CPAs and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as indemnification) with respect to the audit of the insurer.

b. Except as otherwise provided herein, independent certified public accountants shall be recognized as qualified as long as they conform to the standards of their profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and rules and regulations and code of ethics and rules of professional conduct of the Iowa accountancy examining board, or similar code.

c. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Iowa Code chapter 507C, the mediation or arbitration provisions shall operate at the option of the statutory successor.

d. No partner or other person responsible for rendering a report may act in that capacity for more than seven consecutive years. Following any period of service such person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of two years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. The commissioner may consider the following factors in determining if the relief should be granted:

(1) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(2) Premium volume of the insurer; or

(3) Number of jurisdictions in which the insurer transacts business.

The requirements of this paragraph became effective on August 28, 1993.

e. The commissioner shall not recognize as a qualified independent certified public accountant, or accept any annual audited financial report prepared in whole or in part by, any natural person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961-1968, or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this rule.

f. The commissioner of insurance, under 191—Chapter 3, may hold a hearing to determine whether a certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing the opinion of the accountant on the financial statements in the annual audited financial report made pursuant to this rule and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this rule.

5.25(7) *Consolidated or combined audits.* An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report as follows:

a. Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

b. Amounts for each insurer subject to this rule shall be stated separately.

c. Noninsurance operations may be shown on the worksheet on a combined or individual basis.

d. Explanations of consolidating and eliminating entries shall be included.

e. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

5.25(8) *Scope of examination.* Financial statements furnished pursuant to subrule 5.25(4) shall be examined by an independent certified public accountant. The examination of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. Consideration should also be given to such other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

5.25(9) *Notification of adverse financial condition.* The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination or that the insurer does not meet the applicable minimum capital and surplus requirements of Iowa Code sections 508.5, 508.10, 515.8, 515.10 and subsection 515.12(5) as of that date. An insurer who has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five-business-day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five business days.

No independent public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if such statement is made in good faith in compliance with the above paragraph.

If the accountant, subsequent to the date of the audited financial report filed pursuant to this rule, becomes aware of facts which might have affected this report, the insurance division notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU561 of the Professional Standards of the American Institute of Certified Public Accountants.

5.25(10) *Report on significant deficiencies in internal controls.* In addition to the annual audited financial statements, each insurer shall furnish the commissioner with a written report prepared by the accountant describing significant deficiencies in the insurer's internal control structure noted by the accountant during the audit. SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU section 325 of the Professional Standards of the American Institute of Certified Public Accountants) requires an accountant to communicate significant deficiencies (known as "reportable conditions") noted during a financial statement audit to the appropriate parties within an entity. No report should be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the written report shall be filed annually by the insurer with the insurance division within 60 days after the filing of the annual audited financial statements. The insurer is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

5.25(11) *Letter furnished to insurer.* The accountant shall furnish the insurer, in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

a. That the accountant is independent with respect to the insurer and conforms to the standards of the profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and the rules of professional conduct of the Iowa accountancy examining board, or similar code.

b. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this rule shall be construed as prohibiting the accountant from utilizing such staff as is deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

c. That the accountant understands the annual audited financial report and the opinion thereon will be filed in compliance with this rule and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

d. That the accountant consents to the requirements of subrule 5.25(12) and that the accountant consents and agrees to make available for review by the commissioner, or a designee or appointed agent, the workpapers, as defined in subrule 5.25(12).

e. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants.

f. A representation that the accountant is in compliance with the requirements of subrule 5.25(6).

5.25(12) *Definition, availability and maintenance of CPA workpapers.* Workpapers are the records kept by independent certified public accountants of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to their examination of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by independent certified public accountants in the course of their examination of the financial statements of an insurer and which support their opinions thereof.

Every insurer required to file an audited financial report pursuant to this rule shall require the accountant to make available for review by insurance division examiners all workpapers prepared in the conduct of the examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the insurance division, or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the insurance division has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

In the conduct of the aforementioned periodic review by insurance division examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the division. Such reviews by the division examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the division.

5.25(13) *Exemption from compliance.* Upon written application of any insurer, the commissioner may grant an exemption from compliance with this rule if the commissioner finds, upon review of the application, that compliance with this rule would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this rule, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with 191—Chapter 3.

Domestic insurers retaining a certified public accountant on August 28, 1991, who qualify as independent shall comply with this rule for the year ending December 31, 1992, and each year thereafter unless the commissioner permits otherwise.

Domestic insurers not retaining a certified public accountant on August 28, 1991, who qualify as independent may meet the following schedule for compliance unless the commissioner permits otherwise:

a. As of December 31, 1992, file with the commissioner:

(1) Report of independent certified public accountant;

(2) Audited balance sheet;

(3) Notes to audited balance sheet.

b. For the year ending December 31, 1992, and each year thereafter, such insurers shall file with the commissioner all reports required by this rule.

Foreign insurance shall comply with this rule for the year ending December 31, 1992, and each year thereafter unless the commissioner permits otherwise.

5.25(14) *Canadian and British companies.* In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by

such companies with their domiciliary supervision authority duly audited by an independent chartered accountant.

For such insurers, the letter required in subrule 5.25(5) shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the commissioner pursuant to subrule 5.25(3).

This rule is intended to implement Iowa Code section 505.8.

191—5.26(508,515) Participation in the NAIC Insurance Regulatory Information System.

5.26(1) This rule applies to all domestic, foreign and alien insurers who are authorized to transact business in this state.

5.26(2) Each domestic, foreign and alien insurer, except entities organized under Iowa Code chapters 512A, 512B, 514, 514B, 518 and 518A and those which write only in this state, who is authorized to transact insurance in this state shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners (NAIC) a copy of its annual statement convention blank, along with such additional filings as prescribed by the insurance commissioner for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the NAIC.

Foreign insurers that are domiciled in a state which has a law substantially similar to the requirement in the previous sentence shall be deemed in compliance with this rule.

5.26(3) Members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement convention blanks shall be deemed to be acting on behalf of the commissioner by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required under this rule.

5.26(4) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the insurance division by the NAIC Insurance Regulatory Information System are confidential as provided in subrule 191—1.3(11), paragraph *"c."*

5.26(5) The commissioner may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

5.26(6) Electronic filing. The annual financial statement filings required of domestic insurers pursuant to Iowa Code sections 508.11 and 515.63 and the quarterly statement filings required pursuant to rule 191—5.3(507,508,515) must be filed electronically with the National Association of Insurance Commissioners. Electronic filing shall include filing via the Internet or by diskette. The electronic filing must be prepared in accordance with the NAIC Directive to Companies, Coding Conventions, Field Names and Definitions, Data Elements, and Reporting Requirements for Annual/Quarterly Statement Submission on Diskettes. Electronic filings are in addition to and due at the time of the filing of the annual/quarterly financial statement blank with the National Association of Insurance Commissioners. Diskette filings do not need to be filed with the insurance division unless the insurer is directed by the insurance commissioner to submit the filing(s) on diskette. This diskette filing requirement does not apply to entities organized pursuant to Iowa Code chapters 512A, 512B, 514, 514B, 518, and 518A.

This rule is intended to implement Iowa Code sections 508.11 and 515.63.

191—5.27(508,515,520) Asset valuation.

5.27(1) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

a. If purchased at par, at the par value.

b. If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the

purchase was made or, in lieu of such method, according to such accepted method of valuation as is approved by the division.

c. Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of such securities.

5.27(2) The division shall have full discretion in determining the method of calculating values according to the procedures set forth in this rule, but no such method or valuation shall be inconsistent with any applicable valuation or method used by insurers in general, or any method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

5.27(3) Securities, other than those referred to in subrule 5.27(1), held by an insurer shall be valued, in the discretion of the division, at their market value, or at their appraised value, or at prices determined by it as representing their fair market value.

5.27(4) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the division and in accordance with such method of valuation as it may approve.

5.27(5) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value of the subsidiary as based upon only those assets of the subsidiary which would be eligible under Iowa Code section 521A.2 had investment of the funds of the insurer been made directly.

5.27(6) No valuations under this rule shall be inconsistent with any applicable valuation or method formulated or approved by the National Association of Insurance Commissioners.

191—5.28(508,515,520) Risk-based capital and surplus. Capital and surplus requirements in Iowa Code chapters 508, 518 and 520 are minimums. The commissioner retains the discretion to require greater amounts than set forth in those chapters when the risk-based circumstances of a particular insurer, including the type, nature and volume of business being written, require it.

191—5.29(508,515) Actuarial certification of reserves. An opinion on life and health policy and claim reserves and property and casualty loss and loss adjustment expense reserves by a qualified actuary is required in the annual statement blank for all domestic insurers under the terms and conditions contained in the annual statement instructions handbook of the National Association of Insurance Commissioners. All other provisions of the handbook shall be applicable to annual and quarterly financial statements filed with the division.

These rules are intended to implement Iowa Code sections 508.5, 508.9, 508.10, 508.11, 515.8, 515.10, 515.12 and 515.63.

191—5.30(515) Single maximum risk—fidelity and surety risks. No insurance company is permitted under the limitations of Iowa Code section 515.49 to expose itself to any risk on a fidelity or surety bond in excess of 10 percent of its surplus to policyholders, unless such excess shall be reinsured in accordance with the provisions of the statute.

191—5.31(515) Reinsurance contracts. No credit will be given the ceding insurer for reinsurance made, ceded, or renewed unless the reinsurance agreements (treaty, facultative or otherwise) substantially provide, or are amended by a supplemental contract to read in substance as follows:

In consideration of the continuing benefits to accrue hereunder to the assuming insurer, the assuming insurer hereby agrees that, as to all reinsurance made, ceded, or renewed the reinsurance shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer.

191—5.32(511,515) Investments in medium grade and lower grade obligations.

5.32(1) *Reason for promulgation.* The insurance division is concerned that changes in economic conditions and other market variables could adversely affect domestic insurers having a high concentration of these investments. Accordingly, the division has concluded that a limitation on the percentage of total admitted assets that a domestic insurer may prudently invest in such obligations is

reasonable, necessary and required in order to carry out the division's responsibilities under relevant statutory law.

The division understands that medium grade and lower grade obligations can have a place in a well diversified portfolio. However, it is also understood that the special risks associated with these investments require a high degree of management even when they are held within an aggregate limit. While this rule will leave all domestic insurers with authority to invest a substantial portion of their assets in medium grade and lower grade obligations, the prudent management of the attendant risk will remain an essential element of such investing.

5.32(2) *Purposes.* The purposes of this rule are:

a. To protect the interests of the insurance-buying public by establishing limitations on the concentration of medium grade and lower grade obligations in which a domestic insurer can invest;

b. To regulate the acts and practices of domestic insurers with respect to the concentration of investments in medium grade and lower grade obligations. An insurer's obligations of these classifications shall not exceed the greater of those allowed in subrule 5.10(2) or Iowa Code section 515.35(4)*"e,"* whichever is applicable, or this rule.

5.32(3) *Definitions.* As used in this rule:

"Admitted assets" means the amount thereof as of the last day of the most recently concluded annual statement year, computed in accordance with rule 191—5.6(505,515,520).

"Aggregate amount" of medium grade and lower grade obligations means the aggregate statutory statement value thereof.

"Institution" means a corporation, a joint-stock company, an association, a trust, a business partnership, a business joint venture or similar entity.

"Lower grade obligations" means obligations which are rated four, five or six by the Securities Valuation Office of the National Association of Insurance Commissioners.

"Medium grade obligations" means obligations which are rated three by the Securities Valuation Office of the National Association of Insurance Commissioners.

5.32(4) *Provisions.*

a. No domestic insurer shall acquire, directly or indirectly, any medium grade or lower grade obligation of any institution if, after giving effect to any such acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the domestic insurer would exceed 20 percent of its admitted assets provided that:

(1) No more than 10 percent of its admitted assets consists of obligations rated four, five or six by the Securities Valuation Office;

(2) No more than 3 percent of its admitted assets consists of obligations rated five or six by the Securities Valuation Office;

(3) No more than 1 percent of its admitted assets consists of obligations rated six by the Securities Valuation Office. Attaining or exceeding the limit of any one category shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multicategory limits.

b. No domestic insurer may invest more than an aggregate of 1 percent of its admitted assets in medium grade obligations issued, guaranteed or insured by any one institution, nor may it invest more than one-half of 1 percent of its admitted assets in lower grade obligations issued, guaranteed or insured by any one institution. In no event, however, may a domestic insurer invest more than 1 percent of its admitted assets in any medium or lower grade obligations issued, guaranteed or insured by any one institution.

c. Nothing contained in this rule shall prohibit a domestic insurer from acquiring any obligations which it has committed to acquire if the insurer would have been permitted to acquire that obligation pursuant to this rule on the date on which such insurer committed to purchase that obligation.

d. Notwithstanding the foregoing, a domestic insurer may acquire an obligation of an institution in which the insurer already has one or more obligations if the obligation is acquired in order to protect an investment previously made in the obligations of the institution, provided that all such acquired obligations shall not exceed one-half of 1 percent of the insurer's admitted assets.

e. Nothing contained in this rule shall prohibit a domestic insurer from acquiring an obligation as a result of a restructuring of a medium or lower grade obligation already held.

f. Nothing contained in this rule shall require a domestic insurer to sell or otherwise dispose of any obligation legally acquired prior to January 29, 1991.

g. The board of directors of any domestic insurance company which acquires or invests, directly or indirectly, more than 2 percent of its admitted assets in medium grade and lower grade obligations of any institution shall adopt a written plan for the making of such investments. The plan, in addition to guidelines with respect to the quality of the issues invested in, shall contain diversification standards including, but not limited to, standards for issuer, industry, duration, liquidity and geographic location.

This rule is intended to implement Iowa Code sections 511.8 and 515.35.

191—5.33(510) Credit for reinsurance.

5.33(1) *Purpose.* The purpose of this rule is to set forth the procedural requirements which the insurance commissioner deems necessary to carry out the provisions of Iowa Code sections 521B.1 to 521B.5. The actions and information required by this rule are hereby declared to be necessary and appropriate to the public interest and for the protection of the ceding insurers in this state.

5.33(2) *Applicability.* This rule shall have no applicability to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

5.33(3) *Reinsurer licensed in this state.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this state as of the date of the ceding insurer's statutory financial statement.

5.33(4) *Accredited reinsurers.*

a. The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which:

(1) Files a properly executed Form AR-1[1] as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

(2) Files with the commissioner a certified copy of a letter or a certificate of authority or of compliance as evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(3) Files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement;

(4) Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission or, in the case of companies with a surplus as regards policyholders of less than $20 million, whose accreditation has been approved by the commissioner.

b. If the commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, the commissioner may upon written notice and hearing revoke the accreditation. No credit shall be allowed a domestic ceding insurer with respect to reinsurance ceded after January 1, 1990, if the assuming insurer's accreditation has been denied or revoked by the commissioner after notice and hearing.

5.33(5) *Reinsurer domiciled and licensed in another state.*

a. The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which as of the date of the ceding insurer's statutory financial statement:

(1) Is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed in) a state which employs standards regarding credit for reinsurance substantially similar to those applicable in this state;

(2) Maintains a surplus as regards policyholders in an amount not less than $20 million;

(3) Files a properly executed Form AR-1[1] with the commissioner as evidence of its submission to this state's authority to examine its books and records.

b. The provisions of this subrule relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used herein, "substantially similar standards" means credit for reinsurance standards which the commissioner determines equal or exceed the standards of this state.

5.33(6) *Reinsurers maintaining trust funds.*

a. The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount prescribed below in a qualified United States financial institution, as determined by the commissioner, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interests. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

b. The following requirements apply to the following categories of assuming insurer:

(1) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to business written in the United States and, in addition, a trusteed surplus of not less than $20 million.

(2) The trust fund for a group of individual unincorporated underwriters shall consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the commissioner annual certifications by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter member of the group.

(3) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholder surplus of $10 billion (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners) and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the assuming insurers' liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall file a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the commissioner annual certifications by the members' domiciliary regulators and their independent public accountants of the solvency of each member of the group.

c. The trust shall be established in a form approved by the commissioner. The trust instrument shall provide that:

(1) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States.

(2) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in trust.

(3) The trust shall be subject to examination as determined by the commissioner.

(4) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

(5) No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year

end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(6) No amendment to the trust shall be effective unless reviewed and approved in advance by the commissioner.

5.33(7) *Credit for reinsurance required by law.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this subrule, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

5.33(8) *Reduction from liability for reinsurance ceded to an unauthorized assuming insurer.* The commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of any of the following:

a. Cash.

b. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets.

c. Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as determined by the commissioner, effective no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

d. Any other form of security acceptable to the commissioner. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer shall be allowed only when the requirements of this rule are met, as determined by the commissioner.

5.33(9) *Trust agreements qualified under subrule 5.33(8).*

a. Definitions. As used in this rule:

"Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

"Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

"Obligations" means:

1. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;
2. Reserves for reinsured losses reported and outstanding;
3. Reserves for reinsured losses incurred but not reported;
4. Reserves for allocated reinsured loss expenses and unearned premiums.

"Qualified United States financial institution" means an institution meeting the requirements of rule 191—32.4(508), except as permitted otherwise by the commissioner.

b. Required conditions:

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as determined by the commissioner.

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this subrule. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subparagraph 5.33(9)*"b"*(4) must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

(4) The trust agreement shall provide that:

1. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

2. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

3. It is not subject to any conditions or qualifications outside of the trust agreement;

4. It shall not contain references to any other agreements or documents except as provided for under subparagraph 5.33(9)*"b"*(11).

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

1. Receive assets and hold all assets in a safe place;

2. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

3. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

4. Notify the grantor and the beneficiary, within ten days, of any deposits to or withdrawals from the trust account;

5. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary;

6. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(10) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

(11) Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this rule, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

1. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

2. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement;

3. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer, in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in subparagraph 5.33(9)*"d"*(1) as may remain executory after such withdrawal and for any period after the termination date.

(12) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by subparagraph 5.33(9)*"d"*(1) so long as these required conditions are included in the trust agreement.

c. Permitted conditions.

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice, and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in 5.33(9)*"d"*(1)"2."

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

d. Additional conditions applicable to reinsurance agreements.

(1) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

1. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

2. Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by the laws of this state for domestic insurers, or any combination of the above provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

3. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

4. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent;

5. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

- To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;
- To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;
- To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses and unearned premium reserves;
- To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(2) The reinsurance agreement may also contain provisions that:

1. Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

- The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or
- After withdrawal and transfer, the market value of the trust account is not less than 102 percent of the required amount.

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

2. Provide for:

- The return of any amount withdrawn in excess of the actual amounts required to comply with 5.33(9)*"d"*(1)"5," first three unnumbered paragraphs, or in the case of 5.33(9)*"d"*(1)"5," last unnumbered paragraph, any amounts that are subsequently determined not to be due; and
- Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(9)*"d"*(1)"5," third unnumbered paragraph.

3. Permit the award by any arbitration panel or court of competent jurisdiction of:

- Interest at a rate different from that provided in 5.33(9)*"d"*(2)"2";
- Court of arbitration costs;
- Attorney's fees;
- Any other reasonable expenses.

(3) Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this division in compliance with the provision of this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Existing agreements. Any trust agreement or underlying reinsurance agreement in existence prior to January 1, 1992, will continue to be acceptable until January 1, 1993, at which time the agreements will have to be in full compliance with this rule for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in subparagraph 5.33(9)*"a"*(1) shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

5.33(10) *Letters of credit qualified under subrule 5.33(8).*

a. The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subparagraph 5.33(10)*"i"*(1). As used in this paragraph, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

b. The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

c. The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

d. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than 30 days' notice prior to expiry date or nonrenewal.

e. The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

f. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

g. The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized pursuant to the organic laws of its chartering jurisdiction to issue letters of credit.

h. If the letter of credit is not issued by a qualified United States financial institution authorized to issue letters of credit, the following additional requirements shall be met:

(1) The issuing United States financial institution shall formally designate a qualified United States financial institution as its agent for the receipt and payment of the drafts;

(2) The "evergreen clause" shall provide for 30 days' notice prior to expiry date for nonrenewal.

i. Reinsurance agreement provisions.

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

1. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

2. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

- To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;
- To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;
- To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves);
- To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

3. All of the provisions required by paragraph 5.33(10)*"i"* should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in this paragraph shall preclude the ceding insurer and assuming insurer from providing for:

1. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(10)*"i"*(1)"2," third unnumbered paragraph.

2. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the event 5.33(10)*"i"*(1)"3," fourth unnumbered paragraph, is applicable, any amounts that are subsequently determined not to be due.

(3) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of 5.33(10)*"i"*(1)"2," require that the parties enter into a "Trust Agreement" which may be incorporated into the reinsurance agreement or be a separate document.

j. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this division unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

5.33(11) *Other security.* A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

5.33(12) *Reinsurance contract.* Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of subrules 5.33(4), 5.33(5), 5.33(6), 5.33(7), or 5.33(9) after the adoption of this rule unless the reinsurance agreement:

a. Includes a proper insolvency clause pursuant to Iowa Code section 507C.32; and

b. Includes a provision whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

5.33(13) *Contracts affected.* All new and renewal reinsurance transactions entered into after January 1, 1992, shall conform to the requirements of this rule if credit is to be given to the ceding insurer for such reinsurance.

This rule is intended to implement Iowa Code chapter 521B.

[1] Available from Insurance Division

191—5.34(508) Actuarial opinion and memorandum.

5.34(1) *Purpose and effective date.* The purpose of this rule is to prescribe:

a. Requirements for statements of actuarial opinion that are to be submitted in accordance with Iowa Code section 508.36 and for memoranda in support thereof;

b. Rules applicable to the appointment of an appointed actuary; and

c. Guidance as to the meaning of "adequacy of reserves."

5.34(2) *Authority.* This rule is issued pursuant to the authority vested in the commissioner of insurance under Iowa Code section 508.36. This rule will take effect for annual statements for the year 2004.

5.34(3) *Scope.* This rule shall apply to all life insurance companies and fraternal benefit societies doing business in this state and to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this state.

This rule shall be applied in a manner that allows the appointed actuary to utilize the actuary's professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

This rule shall be applicable to all annual statements filed with the office of the commissioner after January 1, 2004. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with subrule 5.34(6), and a memorandum in support thereof in accordance with subrule 5.34(7), shall be required each year.

5.34(4) *Definitions.* As used in this rule:

"Actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with subrule 5.34(6) and with applicable actuarial standards.

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

"Annual statement" means that statement required by Iowa Code section 508.11 to be filed annually by the company with the office of the commissioner.

"Appointed actuary" means any individual who is appointed or retained in accordance with the requirements set forth in 5.34(5)*"c"* to provide the actuarial opinion and supporting memorandum as required by Iowa Code section 508.36.

"Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in 5.34(5)*"d."*

"Commissioner" means the insurance commissioner of this state.

"Company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this rule.

"Qualified actuary" means any individual who meets the requirements set forth in 5.34(5)*"b."*

5.34(5) *General requirements.*

a. Submission of statement of actuarial opinion.

(1) There is to be included on or attached to page 1 of the annual statement for each year beginning with the statement filed as of December 31, 2004, the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with 5.34(6).

(2) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

b. Qualified actuary. A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American Academy of Actuaries;

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing, to have:

1. Violated any provision of, or any obligation imposed by, the insurance code or other law in the course of dealing as a qualified actuary;

2. Been found guilty of fraudulent or dishonest practices;

3. Demonstrated incompetency, lack of cooperation, untrustworthiness to act as a qualified actuary;

4. Submitted to the commissioner during the past five years, pursuant to this rule, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this rule including standards set by the Actuarial Standards Board; or

5. Resigned or been removed as an 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 failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under 5.34(5)*"b"*(4).

c. Appointed actuary. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this rule, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in 5.34(5)*"b."* Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in 5.34(5)*"b."* If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

d. Standards for asset adequacy analysis. The asset adequacy analysis required by this rule shall:

(1) Conform to the standards of practice as promulgated from time to time by the Actuarial Standards Board and any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with 5.34(6);

(2) Be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

e. Liabilities to be covered.

(1) Under the authority of Iowa Code section 508.36, the statement of actuarial opinion shall apply to all in-force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 8, 9, and 10, and claim liabilities in Exhibit 11, part 1, and equivalent items in the separate account statement or statements.

(2) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in Iowa Code section 508.36, the company shall establish the additional reserve.

(3) Additional reserves established under 5.34(5)*"e"*(2) and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

5.34(6) *Statement of actuarial opinion based on an asset adequacy analysis.*

a. General description. The statement of actuarial opinion submitted in accordance with this subrule shall consist of:

(1) A paragraph identifying the appointed actuary and the actuary's qualifications (see 5.34(6)*"b"*(1));

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis (see

5.34(6)*"b"*(2)), and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see 5.34(6)*"b"*(3))), supported by a statement of each such expert in the form prescribed by 5.34(6)*"e"*; and

(4) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see 5.34(6)*"b"*(6)).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

1. If the appointed actuary considers it necessary to state a qualification of opinion;
2. If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;
3. If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release;
4. If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

b. Recommended language. The following paragraphs shall be included in the statement of actuarial opinion in accordance with this subrule. Language is that which in typical circumstances should be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses the actuary's professional judgment. However, in any event, the opinion shall retain all pertinent aspects of the language provided in this subrule.

(1) The opening paragraph should generally indicate the appointed actuary's relationship to the company and qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the board of directors of said insurer to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

For a consulting actuary, the opening paragraph should include a statement such as:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the board of directors of [name of company] to render this opinion as stated in the letter to the commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20____. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis."

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 8 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
D Accidental Death Benefit					
E Disability—Active					
F Disability—Disabled					
G Miscellaneous					
Total (Exhibit 8 Item 1, Page 3)					
Exhibit 9 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 9 Item 2, Page 3)					
Exhibit 10 Premiums and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 10 (Column 1, Line 14)					
Exhibit 11, Part 1 1 Life (Page 3, Line 4.2)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 11, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					
IMR (General Account, Page _____ Line _____)					
(Separate Accounts, Page ____ Line _____)					
AVR (Page _____ Line _____)		(c)			
Net Deferred and Uncollected Premium					

Notes:

(a) The additional actuarial reserves are the reserves established under subparagraph (2) of 5.34(5)*"e."*

(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in paragraph 5.34(5)*"d,"* by means of symbols that should be defined in footnotes to the table.

(c) Allocated amount of asset valuation reserve (AVR).

(3) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

"I have relied on [name], [title] for [e.g., 'anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios' or 'certain critical aspects of the analysis performed in conjunction with forming my opinion'], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

Such a statement of reliance on other experts should be accompanied by a statement by each of such experts in the form prescribed by 5.34(6)*"e."*

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

"In forming my opinion on [specify types of reserves], I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The section shall be accompanied by a statement by each person relied upon in the form prescribed by 5.34(6)*"e."*

(6) The opinion paragraph shall include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

"1. Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

"2. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

"3. Meet the requirements of the insurance law and rules of the state of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

"4. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

"5. Include provision for all actuarial reserves and related statement items which ought to be established.

"The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the commissioner, this language may be omitted for an opinion filed on behalf of a company doing business only in this state and in no other state.)

"The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

"The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

"The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____
Signature of Appointed Actuary

_____
Address of Appointed Actuary

_____
Telephone Number of Appointed Actuary

_____
Date"

c. Assumptions for new issues. The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this subrule.

d. Adverse opinion. If the appointed actuary is unable to form an opinion, then the actuary shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then the actuary shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

e. Reliance on information furnished by other persons. If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons upon whom the actuary is relying and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

f. Alternate option.

(1) Iowa Code section 508.36 gives the commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of subparagraph 5.34(6)*"b"*(6), item "3," the commissioner may make one or more of the following additional approaches available to the opining actuary:

1. A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the commissioner chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

2. A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the commissioner for approval of that request have been met." If the commissioner chooses to allow this alternative, a formal written statement of such allowance shall be issued no later than March 31 of the year it is first effective. The statement shall remain valid until rescinded or modified by the commissioner. A rescission or modification of the statement shall be issued no later than March 31 of the year it is first effective. After that statement is issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year the opinion is to

be filed. The request shall be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

3. A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state."

● If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in 5.34(6)*"f"*(1)"3," second bulleted paragraph) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

● If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under National Association of Insurance Commissioners codification standards adopted in rule 191—5.15(508,512B,514,514B,515,520). Gross nationwide reserves are the total reserves calculated for the total company in-force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall include at least the following:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

● The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative.

● If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

● The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(2) Notwithstanding 5.34(6)*"f"*(1), the commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within 60 days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract an independent actuary at the company's expense to prepare and file an opinion.

5.34(7) *Description of actuarial memorandum including an asset adequacy analysis and regulatory asset adequacy issues summary.*

a. General.

(1) In accordance with Iowa Code section 508.36, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of the opinion regarding the reserves. The memorandum shall be made available for examination by the commissioner upon request but shall be returned to the company after such examination and shall not be considered a record of the insurance division or subject to automatic filing with the commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of the actuary's own memorandum, memoranda, prepared and signed by other actuaries who are qualified within the meaning of 5.34(5)*"b"* with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this rule, the commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is

required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company, and the work papers and documentation of the reviewing actuary shall be retained by the commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing this rule. The reviewing actuary shall not be an employee or a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this rule for the current year or the preceding three years.

(5) In accordance with Iowa Code section 508.36, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in 5.34(7)*"c."* The regulatory asset adequacy issues summary shall be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

b. Details of the memorandum section documenting asset adequacy analysis (5.34(6)). When an actuarial opinion under 5.34(6) is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in 5.34(5)*"d"* and any additional standards under this rule. It shall specify:

(1) For reserves:

1. Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;
2. Source of liability in force;
3. Reserve method and basis;
4. Investment reserves;
5. Reinsurance arrangements;
6. Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;
7. Documentation of assumptions to test reserves for the following:

- Lapse rates (both base and excess);
- Interest crediting rate strategy;
- Mortality;
- Policyholder dividend strategy;
- Competitor or market interest rate;
- Annuitization rates;
- Commissions and expenses; and
- Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) For assets:

1. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;
2. Investment and disinvestment assumptions;
3. Source of asset data;
4. Asset valuation bases; and
5. Documentation of assumptions made for:

- Default costs;
- Bond call function;
- Mortgage prepayment function;

- Determining market value for assets sold due to disinvestment strategy; and
- Determining yield on assets acquired through the investment strategy.

The documentation of assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) For the analysis basis:

1. Methodology;

2. Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

3. Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how vigorously to analyze different blocks of business);

4. Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

5. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis.

(4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis.

(5) Conclusion(s).

c. Details of the regulatory asset adequacy issues summary.

(1) The regulatory asset adequacy issues summary shall include:

1. Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserves as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in-force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force;

2. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis;

3. The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

4. Comments on any interim results that may be of significant concern to the appointed actuary;

5. The methods used by the actuary to recognize the impact of reinsurance on the company cash flows, including both assets and liabilities, under each of the scenarios tested; and

6. Whether the actuary has been satisfied that all options, whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equitylike features in any investments have been appropriately considered in the asset adequacy analysis.

(2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

d. Conformity to standards of practice. The memorandum shall include the following statement: "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate standards of practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

e. Use of assets supporting the interest maintenance reserve and the asset valuation reserve. An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR

assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of assets used for the AVR shall be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

f. Documentation. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

This rule is intended to implement Iowa Code section 508.36.

191—5.35 to **5.39** Reserved.

191—5.40(515) Premium tax. The fact that the companies choose to call a stipulated amount a "policy fee" and do not include it under the term of "premium" would not have the effect of exempting this income from taxation. It is most assuredly a part of the premium or income received from policyholders for business done in Iowa and thus subject to taxation.

191—5.41(508) Tax on gross premiums—life companies. In determining the gross amount of premiums to be taxed hereunder, there shall be excluded:

1. All premiums returned to policyholders or annuitants during the preceding calendar year, except cash surrender values.
2. All dividends that, during said year, have been paid in cash or applied in reduction of premiums or left to accumulate to the credit of policyholders or annuitants.

191—5.42(432) Cash refund of premium tax. A cash refund of premium tax may be made to an insurance company that has paid a premium tax payment or prepayment and demonstrates an inability to recoup the funds paid via a credit, provided that the insurance division determines that a refund is appropriate. A claim for refund is a formal request made by the insurance company or its successor in interest to the insurance division for repayment of premium tax prepayments that were paid with the insurance company's previously filed tax return. The claim for refund shall not be filed with a premium tax prepayment, annual tax payment, or with other documents or forms submitted to the division.

5.42(1) *Eligibility criteria.* Upon the written application of an insurance company or its successor in interest, the insurance division shall authorize the department of revenue to make a cash refund to an insurer if:

a. The insurance company is subject to an order of liquidation or equivalent order issued by a court of competent jurisdiction; or

b. The insurance company has not written any business in the state of Iowa for five years; or

c. The insurance company's certificate of authority is voluntarily or involuntarily surrendered or terminated; upon application for a refund, the company shall be prohibited from applying for readmission in Iowa for at least five years; and

d. The insurance company has no insurer within its holding company which could utilize the credit.

5.42(2) *Application procedure.* An insurance company may file a claim for a cash refund with the insurance division by stating in detail the reasons and facts and including supporting documents with the claim for a cash refund. These documents shall include but not be limited to:

a. A written request applying for a cash refund and identifying the address where the cash refund should be mailed;

b. A copy of the tax return from which the premium tax credit originated;

c. A copy of the liquidation order or other documentation demonstrating that the insurance company's certificate of authority has been surrendered and that the company is prohibited from applying for admission in Iowa for at least five years; and

d. A certification from the chief executive officer stating that the company has no plans for writing business in the state of Iowa and agrees to notify the insurance division before writing any business in this state if the claim for refund is made pursuant to 5.42(1)*"b."*

5.42(3) *Appeals.* If the claim for refund is denied and the applicant wishes to appeal the denial, the insurance division will consider an appeal to be timely if filed not later than 30 days following the date of denial.

5.42(4) *Statute of limitations.* Upon meeting the eligibility criteria outlined in 5.42(1), an insurance company has up to five years to file an application for a refund. A refund will not be authorized if an application is not made within this time frame.

This rule is intended to implement Iowa Code section 432.1(6).

191—5.43(510) Managing general agents.

5.43(1) The requirement that a domestic insurer submit its contracts with managing general agents for approval of the commissioner of insurance set forth in Iowa Code section 510.2 remains in effect after July 1, 1991.

5.43(2) A managing general agent shall at all times maintain a surety bond in the amount of $50,000 issued by an insurer licensed to transact business in this state for the benefit of each domestic insurer with which the managing general agent has contracted.

5.43(3) A managing general agent shall maintain an errors and omissions policy in the face amount of $250,000.

5.43(4) A third-party administrator subject to Iowa Code chapter 510 shall not be deemed to be a managing general agent.

5.43(5) The amount of claims in excess of which a person is authorized to adjust or pay for purposes of the definition of "managing general agent" in Iowa Code section 510.2A(4)*"a"*(3)*"a"* is $15,000 per claim.

DISCLOSURE OF MORTGAGE LOAN APPLICATIONS

191—5.44 to **5.49** Reserved.

191—5.50(535A) Purpose. These rules are adopted for the purpose of enforcing Iowa Code sections 535A.2 and 535A.4.

191—5.51(535A) Definitions.

5.51(1) *"Reporting financial institution"* means a person which holds a certificate of authority to act as an insurer pursuant to any provision of Title XX, Iowa Code, if the person:

a. At the beginning of a reporting period possessed assets in excess of $10 million; and

b. During a reporting period received applications for mortgage loans on residential property situated in any Iowa city with a population in excess of 50,000, as determined in the most recent census, or in any standard metropolitan statistical area.

5.51(2) *"Application"* means an oral or written request for an extension of credit that is made in accordance with procedures established by a financial institution for the type of credit requested.

5.51(3) *"Reporting period"* means the calendar year beginning January 1, 1979, and each calendar year thereafter.

5.51(4) *"Mortgage loan"* means a mortgage loan as defined in Iowa Code section 535A.1, which is secured by a primary or secondary lien against residential property located in this state.

5.51(5) *"Residential property"* means real property used or to be used for residential purposes, including single family homes, dwellings for from two to four families and individual units of condominiums and townhouses.

5.51(6) *"Residential mortgage loan"* means a mortgage loan other than a construction loan, a home improvement loan or a rehabilitation loan.

5.51(7) *"Construction loan"* means a loan for a maximum of two years for the purpose of construction.

5.51(8) *"Interest rate"* means the rate stated on the indenture.

5.51(9) *"Standard metropolitan statistical area"* means an area located wholly or partly in the state of Iowa which is designated a standard metropolitan statistical area by the United States Department of Commerce.

191—5.52(535A) Filing of reports.

5.52(1) Every reporting financial institution shall file the reports required by rule 191—5.53(535A) with the director of the Iowa housing finance authority, Des Moines, Iowa 50319, and with the commissioner of insurance, Des Moines, Iowa 50319, on or before January 15, 1980, and each year thereafter by January 15, and shall maintain a copy of each report at the office where its principal financial records are maintained for a period of five years after it is filed.

5.52(2) Reporting financial institutions shall file a report which complies with the Federal Home Mortgage Act of 1975, 12 U.S.C. 2801 to 2809, and regulations promulgated under that Act. Reporting financial institutions shall also report additional information required by rule 191—5.54(535A).

191—5.53(535A) Form and content of reports.

5.53(1) Reports required by rule 191—5.53(535A) shall be filed on Disclosure Form A[1] or a form similar thereto.

5.53(2) Financial institutions may submit computer printouts in lieu of the specimen form if the computer printouts contain the same information in the same sequence as on the specimen form.

5.53(3) Every report filed shall disclose the following information:

a. Name and address of the reporting financial institution.

b. Name, address and telephone number of the officer designated by the reporting financial institution to file the report.

c. Reporting period.

d. The principal amount of a loan shall be disclosed with respect to construction loan applications, home improvement loan applications, total mortgage loan applications, and residential mortgage loan applications, and the requested amount shall be disclosed with respect to construction loan applications not approved, home improvement loan applications not approved, total mortgage loan applications not approved and residential mortgage loan applications not approved. The principal and requested amount disclosures required above shall be reported separately for each census tract or zip code area.

5.53(4) Each report shall also indicate the number of persons requesting to examine the disclosure report for the previous reporting period.

[1] Form omitted under Iowa Code section 17A.6(3). They are available upon request from the agency.

191—5.54(535A) Additional information required.

5.54(1) Reporting financial institutions shall file with the commissioner of insurance on or before March 15 of each year Disclosure Form B or a form similar thereto the following additional information with respect to loans for the purchase of residential property made during the preceding year:

a. The number of loans approved at each of the following percentages of the appraised value of the property used as security for the loan:

(1) Less than 60 percent
(2) 60 percent to 69 percent
(3) 70 percent to 79 percent
(4) 80 percent to 89 percent
(5) 90 percent or more

b. The number of loans approved for each of the following amortization periods:

(1) Less than 10 years
(2) 10 to 14 years

(3) 15 to 19 years
(4) 20 to 24 years
(5) 25 to 29 years
(6) 30 or more

c. The number of loans made at each interest rate charged.

5.54(2) Reporting financial institutions are not required to file the additional information required by subrule 5.54(1) for any loan guaranteed in whole or part under any program of the United States or any of its agencies or instrumentalities, if:

a. The reporting financial institution made a written loan commitment for the loan at the maximum rate of interest permitted under the program at the time of the commitment, and

b. The amortization period for a loan is the maximum period permitted under the program or a shorter period established in response to a request initiated solely by the borrower, and

c. The loan is made at the maximum percentage of appraised value of the property permitted under the program or for the total amount which the borrower desired to borrow, and

d. The reporting financial institution files with the commissioner of insurance on or before March 15 of each year its verified statement, signed by an officer of the reporting financial institution, that it has made loans under such a program and that it has filed the report required by rule 5.54(2) for each such loan not exempted by this rule.

191—5.55(535A) Written complaints. Any person who has reason to believe that a financial institution has failed to comply with the provisions of Iowa Code chapter 535A or these rules may file a written complaint with the insurance division, Des Moines, Iowa 50319, or bring an action in the district court in accordance with Iowa Code chapter 535A.

These rules are intended to implement Iowa Code sections 535A.2 and 535A.4.

191—5.56 to **5.89** Reserved.

191—5.90(145) Implementation of health data commission directives. Rescinded IAB 11/15/00, effective 12/20/00.

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◊ Two or more ARCs

CHAPTER 6
ORGANIZATION OF DOMESTIC INSURANCE COMPANIES

[Appeared as ch 4, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

191—6.1(506) Definitions.

6.1(1) *"Promoters"* shall mean any incorporator, organizer, founder or other person or corporation who, acting alone or in concert with other persons, is initiating or directing, or has within one year initiated or directed, the organization of a new insurance company.

6.1(2) *"Public moneys"* shall mean the price paid by persons other than promoters for securities.

191—6.2(506) Promoters contributions. Promoters shall invest of their own funds at least 20 percent of the proposed issue in cash. If something other than cash is contemplated to meet the requirements of this rule, it shall be valued by the commissioner of insurance in accordance with the provisions of Iowa Code section 492.7.

191—6.3(506) Escrow. All public moneys shall be escrowed 100 percent until the issue is sold unless sooner released by written order of the commissioner of insurance; in the event the issue is not completely sold, all expenses incurred in corporate organization, sale of securities and cost of liquidation shall be paid from funds acquired from promoters.

191—6.4(506) Alienation. In the event of a public offering, no securities held by the promoters shall, for a three-year period from the date of acquisition, be alienated or hypothecated (except by operation of the law) unless the operation of the insurance company produces earned surplus for two consecutive years.

191—6.5(506) Sales to promoters. In the event of a public offering, no securities shall be acquired by promoters at less than the public offering price.

191—6.6(506) Options. In the event of public offering, stock options or warrants acquired by promoters shall not exceed 10 percent of the issue.

191—6.7(506) Qualifications of management. The general plan of organization as contemplated in Iowa Code section 506.3 shall include proposed management personnel with biographical sketches, including state of residence and complete insurance experience of each.

191—6.8(506) Chief executive. The chief executive officer of a newly organized insurance company shall be a bona fide resident of Iowa and unless removed for cause and while acting in this capacity shall devote the entire time to such duties unless this requirement is specifically waived by written order of the commissioner of insurance. For purposes of this rule, a newly organized insurance company shall be deemed to be a company in existence for three years or less.

191—6.9(506) Directors. The majority of the directors shall be bona fide residents of the state of Iowa unless specifically waived by written permission of the commissioner of insurance.

These rules are intended to implement Iowa Code section 506.1.

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CHAPTER 7
DOMESTIC STOCK INSURERS PROXIES

PROXY REGULATIONS
[Appeared as ch 6, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

191—7.1(523) Application of regulation. This regulation is applicable to all domestic stock insurers having 100 or more stockholders; provided, however, that this regulation shall not apply to any insurer if 95 percent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than 500 stockholders. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities and Exchange Act of 1934 and the Securities and Exchange Acts Amendments of 1964 and regulation X-14 of the Securities and Exchange Commission promulgated thereunder shall be exempt from the provisions of this regulation.

191—7.2(523) Proxies, consents and authorizations. No domestic stock insurer, or any director, officer or employee of such insurer subject to 7.1(523) hereof, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any stock of such insurer in contravention of this regulation and Schedules A and B hereto annexed and hereby made a part of this regulation.

191—7.3(523) Disclosure of equivalent information. Unless proxies, consents or authorizations in respect of a stock of a domestic insurer subject to 7.1(523) hereof are solicited by or on behalf of the management of such insurer from the holders of record of stock of such insurer in accordance with this regulation and the schedules thereunder prior to any annual or other meeting, such insurer shall, in accordance with this regulation and such further regulations as the commissioner may adopt, file with the commissioner, and transmit to all stockholders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

191—7.4(523) Definitions.

7.4(1) The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, shall be applicable for purposes of this regulation.

7.4(2) The terms "solicit" and "solicitation" for purposes of this regulation shall include:

a. Any request for proxy, whether or not accompanied by or included in a form of proxy; or

b. Any request to execute or not to execute, or to revoke, a proxy; or

c. The furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

7.4(3) The terms "solicit" and "solicitation" shall not include:

a. Any solicitation by a person in respect of stock of which the person is the beneficial owner;

b. Action by a broker or other person in respect to stock carried in that person's name or in the name of that person's nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

c. The furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

191—7.5(523) Information to be furnished to stockholders.

7.5(1) No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

7.5(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to 7.5(1) hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

7.5(3) Two copies of each report sent to the stockholder pursuant to this rule shall be mailed to the commissioner not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the commissioner pursuant to 7.7(1), whichever date is later.

191—7.6(523) Requirements as to proxy.

7.6(1) The form of proxy *(a)* shall indicate in bold-face type whether or not the proxy is solicited on behalf of the management, *(b)* shall provide a specifically designated blank space for dating the proxy, and *(c)* shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or stockholders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to 7.6(3) hereof.

7.6(2) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in bold-face type how it is intended to vote the shares or authorization represented by the proxy in each such case.

7.6(3) A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

7.6(4) No proxy shall confer authority *(a)* to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or *(b)* to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

7.6(5) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to 7.6(2) hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

7.6(6) The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented.

191—7.7(523) Material required to be filed.

7.7(1) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the commissioner at least ten days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the commissioner may authorize upon a showing of good cause therefor.

7.7(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with

the commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the commissioner may authorize upon a showing of good cause therefor.

7.7(3) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the commissioner not later than the date such material is first sent or given to the stockholders.

7.7(4) Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes.

7.7(5) Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this rule.

7.7(6) Notwithstanding the provisions of 7.7(1) and 7.7(2) hereof and of 7.10(5), copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the commissioner as required by 7.7(3) hereof not later than the date such material is used or published. The provisions of 7.7(1) and 7.7(2) hereof and 7.10(5) shall apply, however, to any reprints or reproductions of all or any part of such material.

191—7.8(523) False or misleading statements. No solicitation subject to this regulation shall be made by means of any proxy statement, form of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading.

191—7.9(523) Prohibition of certain solicitations. No person making a solicitation which is subject to this regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

191—7.10(523) Special provisions applicable to election contests.

7.10(1) *Applicability.* This rule shall apply to any solicitation subject to this regulation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

7.10(2) *Participant or participant in a solicitation.*

a. For purposes of this rule the term "participant" and "participant in a solicitation" include: (1) The insurer; (2) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (3) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

b. For the purposes of this rule the term "participant" and "participant in a solicitation" do not include: (1) A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant; (2) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy-soliciting material or performs ministerial or clerical duties; (3) any person employed in the capacity of attorney, accountant or advertising, public relations or financial adviser, and whose activities are limited to the performance of the person's duties in the course of such employment; (4) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (5) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

7.10(3) *Filing of information required by Schedule B.*

a. No solicitation subject to this rule shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the commissioner may

authorize upon a showing of good cause therefor, there has been filed, with the commissioner by or on behalf of each participant in such solicitation a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the commissioner's comments have been received and complied with.

b. Within five business days after a solicitation subject to this rule is made by the management of an insurer, or such longer period as the commissioner may authorize upon a showing of good cause therefor, there shall be filed with the commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

c. If any solicitation on behalf of a management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this rule in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the commissioner by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

d. If, subsequent to the filing of the statements required by paragraphs *"a," "b"* and *"c"* of this subrule, additional persons become participants in a solicitation subject to this rule, there shall be filed with the commissioner by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the commissioner may authorize upon a showing of good cause therefor.

e. If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the commissioner.

f. Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the commissioner.

7.10(4) *Solicitations prior to furnishing required written proxy statement.* Notwithstanding the provisions of 7.5(1), a solicitation subject to this rule may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that:

a. The statements required by 7.10(3) hereof are filed by or on behalf of each participant in such solicitation.

b. No form of proxy is furnished to stockholders prior to the time the written proxy statement required by 7.5(1) is furnished to such persons. Provided, however, that this paragraph *"b"* shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

c. At least the information specified in paragraphs *"b"* and *"c"* of the statements required by 7.10(3) hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

d. A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

7.10(5) *Solicitations prior to furnishing required written proxy statement—Filing requirements.* Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by 7.5(1) shall be filed with the commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the commissioner may authorize upon a showing of good cause therefor.

7.10(6) *Application of this section to report.* Notwithstanding the provisions of 7.5(2) and 7.5(3), two copies of any portion of the report referred to in 7.5(2) which comments upon or refers to any solicitation subject to this rule, or any participant in any such solicitation, other than the solicitation by the management, shall be filed with the commissioner, as proxy material subject to this regulation. Such portion of the report shall be filed with the commissioner, in preliminary form, at least five business days prior to the date copies of the report are first sent or given to stockholders.

These rules are intended to implement Iowa Code chapter 523.

SCHEDULE A
INFORMATION REQUIRED IN PROXY STATEMENT

Item 1. Revocability of proxy. State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2. Dissenters' rights of appraisal. Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3. Persons making solicitations not subject to 7.10(523).

a. If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he tends to oppose.

b. If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

c. If the solicitation is to be made by specially engaged employees or paid solicitors, state (1) the material features of any contract or arrangement for such solicitation and identify the parties, and (2) the cost or anticipated cost thereof.

Item 4. Interest of certain persons in matters to be acted upon. Describe briefly any substantial interest, direct or indirect, by stockholdings or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

Item 5. Stocks and principal stockholders.

a. State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

b. Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, indicate the conditions under which other stockholders may be entitled to vote.

c. If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6. Nominees and directors. If action is to be taken with respect to the election of directors furnish the following information in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting:

a. Name each person, state expiration of term of office or the term of office for which the person is a nominee will expire, and all other positions and office with the insurer presently held by that person, and indicate which persons are nominees for election as directors at the meeting.

b. State the nominee's present principal occupation or employment and give the name and principal business of any corporation or other organization in which employment is carried on. Furnish similar information as to all of the nominee's principal occupations or employments during the last five years, unless the nominee is now a director and was elected to the present term of office by a vote of stockholders at a meeting for which proxies were solicited under this regulation.

c. If the nominee is or has previously been a director of the insurer, state the period or periods during which the nominee has served.

d. State, as of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by the director. If the director is not the beneficial owner of any such stocks make a statement to that effect.

Item 7. Remuneration and other transactions with management and others. Furnish the information reported or required in Item One of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to *(a)* the election of directors, *(b)* any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, *(c)* any pension or retirement plan in which any such person will participate, or *(d)* the granting or extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the management, information shall be furnished only as to Item 1-A of the aforesaid heading of Schedule SIS.

Item 8. Bonus, profit sharing and other remuneration plans. If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, of the insurer, furnish the following information:

a. A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

b. The amounts which would have been distributable under the plan during the last calendar year to (1) each person named in item 7 of this schedule, (2) directors and officers as a group, and (3) all other employees as a group, if the plan had been in effect.

c. If the plan to be acted upon may be amended (other than by a vote of the stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph *"b"* of this item, the nature of such amendments should be specified.

Item 9. Pension and retirement plans. If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

a. A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

b. State (1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (2) the estimated annual payment to be made with respect to current services; and (3) the amount of such annual payments to be made for the benefit of each person named in item 7 of this schedule, directors and officers as a group, and employees as a group.

c. If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph *"b"*(3) of this item, the nature of such amendments should be specified.

Item 10. Options, warrants, or rights. If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro rata basis, furnish the following information:

a. The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

b. If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following persons, naming each such person: (1) Each person named in item 7 of this schedule, and (2) each other person who will be entitled to acquire 5 percent or more of the stock called for or to be called for by such warrants.

c. If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or issuance of stock.

a. If action is to be taken with respect to the authorization or issuance of any stock of the insurer furnish the title, amount and description of the stock to be authorized or issued.

b. If the shares of stock are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

c. If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the commissioner may require financial statements comparable to those contained in the annual report.

Item 12. Mergers, consolidations, acquisitions and similar matters.

a. If action is taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(1) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(2) The material features of the plan or agreement.

(3) The business done by the company to be acquired or whose assets are being acquired.

(4) If available, the high and low sales prices for each quarterly period within two years.

(5) The percentage of outstanding shares which must approve the transaction before it is consummated.

b. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(1) A comparative balance sheet as of the close of the last two fiscal years.

(2) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earnings per share after related taxes and cash dividends paid per share.

(3) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of accounts. If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

a. State the nature of the restatement and the date as of which it is to be effective.

b. Outline briefly the reasons for the restatement and for the selection of the particular effective date.

c. State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14. Matters not required to be submitted. If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15. Amendment of charter, bylaws or other documents. If action is to be taken with respect to any amendment of the insurer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

SCHEDULE B
INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST

Item 1. Insurer. State the name and address of the insurer.

Item 2. Identity and background.

a. State the following:

(1) Your name and business address.

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

b. State the following:

(1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

c. State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

d. State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this subitem need not be included in the proxy statement or other proxy-soliciting material.

Item 3. Interest in stock of the insurer.

a. State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

b. State the amount of each class of stock of the insurer which you own of record but not beneficially.

c. State with respect to the stock specified in *"a"* and *"b"* the amounts acquired within the past two years, the dates of acquisition and the amounts acquired on each date.

d. If any part of the purchase price or market value of any of the stock specified in paragraph *"c"* is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

e. State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.

f. State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

g. State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4. Further matters.

a. Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

b. Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

c. State whether or not you or any of your associates have any arrangement or understanding with any person:

(1) With respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) With respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereto.

Item 5. Signature. The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

Date	(Signature of participant or authorized representative)

POLICYHOLDER PROXY SOLICITATION

191—7.11(523) Application. These rules are applicable to all domestic mutual insurance companies.

191—7.12(523) Conditions—revocation. No proxy shall be valid unless signed and executed within two months prior to such meeting or election for which said proxy was given, and such proxy shall be limited to 30 days subsequent to the date of such meeting or election, and may be revoked at any time by the policyholder who executed the said proxy.

191—7.13(523) Filing proxy. All proxies shall be filed with the company at least one day prior to any meeting or election at which they are to be used.

191—7.14(523) Solicitation by agents—use of funds. Soliciting of proxies by an agent of a company either for personal use, or for the use of officers of the company or for any other person or persons, is forbidden. Company funds shall not be expended in procuring proxies.

191—7.15 to **7.19** Reserved.

STOCK TRANSACTION REPORTING

191—7.20(523) Statement of changes of beneficial ownership of securities.

7.20(1) *Directors, executive officers, and principal stockholders of domestic insurers required to file.* Every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of an insurer exempt from the filing requirements of Section 16 of the Securities Exchange Act of 1934 pursuant to Section 12(g)(2)(G) of the Act, or who is a director or an executive officer of the issuer of such security, shall file the statements required by this rule with the commissioner.

7.20(2) *Time of filing.*

a. An initial statement of beneficial ownership form shall be filed:

(1) Within ten days after a person becomes such beneficial owner, director, or executive officer;

(2) Within ten days after the insurer would become subject to filing requirements under Section 16 of the Securities Exchange Act of 1934 but for the exemptions set forth in Section 12(g)(2)(G) of the Act; or

(3) Within ten days after the effective date of an insurer's filing of a registration statement registering a class of equity securities on a national securities exchange.

b. An annual statement of beneficial ownership form shall be filed by each director, executive officer or beneficial owner of more than 10 percent of any class of any equity security within 45 days of the end of each fiscal year.

c. A statement of changes in beneficial ownership form shall be filed by each director, executive officer or beneficial owner of more than 10 percent of any class of any equity security before the end of the second business day following the day on which a transaction resulting in a change in beneficial ownership has been executed.

7.20(3) *Exceptions to the two-business-day filing deadline.*

a. Definitions.

"Discretionary transaction" means a transaction pursuant to an employee benefit plan that:

1. Is at the volition of the participant;

2. Is not made in connection with the participant's death, disability, retirement or termination of employment;

3. Is not required to be made available to a plan participant pursuant to a provision of the Internal Revenue Code of 1986; and

4. Results in either an intra-plan transfer involving an issuer equity securities fund or a cash distribution funded by a volitional disposition of an issuer equity security.

"Excess benefit plan" means an employee benefit plan that is operated in conjunction with a qualified plan and provides only the benefits or contributions that would be provided under a qualified plan but for any benefit or contribution limitations set forth in the Internal Revenue Code of 1986.

"Internal Revenue Code of 1986" means the Internal Revenue Code of 1986 as amended through July 1, 2005, or if later, the date provided for in Iowa Code section 422.3(5).

"Qualified plan" means an employee benefit plan that satisfies the coverage and participation requirements of Sections 410 and 401(a)(26) of the Internal Revenue Code of 1986.

"Stock purchase plan" means an employee benefit plan that satisfies the coverage and participation requirements of Sections 423(b)(3) and 423(b)(5), or Section 410, of the Internal Revenue Code of 1986.

b. Any acquisition of securities resulting from the reinvestment of dividends or interest on securities of the same issuer shall be exempt from the filing requirements under paragraph 7.20(2)*"c"* if the acquisition is made pursuant to a plan providing for the regular reinvestment of dividends or interest and the plan provides for broad-based participation, does not discriminate in favor of employees of the issuer, and operates on substantially the same terms for all plan participants.

c. Any transaction (other than a discretionary transaction) pursuant to a qualified plan, and excess benefit plan, or a stock purchase plan shall be exempt from the filing requirements under paragraph 7.20(2)*"c"* without condition.

d. The increase or decrease in the number of securities held as a result of a stock split or stock dividend applying equally to all securities of that class, including a stock dividend in which equity securities of a different issuer are distributed, shall be exempt from the filing requirements under paragraph 7.20(2)*"c."*

e. The acquisition or disposition of equity securities pursuant to a domestic relations order, as defined in the Internal Revenue Code of 1986; or the Employee Retirement Income Security Act, or the rules thereunder, shall be exempt from the filing requirements under paragraph 7.20(2)*"c."*

f. Any transaction exempt from the filing requirements under paragraph 7.20(2)*"c"* pursuant to 7.20(3) shall nonetheless be included in any subsequent filing required under paragraph 7.20(2)*"a"* or *"b."*

7.20(4) *Content of statements.*

a. A statement filed under paragraph *"a"* or *"b"* of subrule 7.20(2) shall contain a statement of the amount of all equity securities of such issuer of which the filing person is the beneficial owner; and

b. A statement filed under paragraph *"c"* of subrule 7.20(2) shall indicate ownership by the filing person at the date of filing and any change in ownership since the most recent filing.

7.20(5) *Electronic filing and availability.*

a. A statement filed under subrule 7.20(2) may be filed electronically; and

b. The insurer (if the insurer maintains a corporate Web site) shall post each statement on its corporate Web site no later than the end of the second business day following the filing of the statement.

This rule is intended to implement Iowa Code section 523.7.

These rules are intended to implement Iowa Code chapter 523.

[Filed 4/15/66]

[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed emergency 11/30/05—published 12/21/05, effective 12/31/05]

CHAPTER 8
BENEVOLENT ASSOCIATIONS

[Appeared as ch 7, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

191—8.1 and **8.2** Reserved.

191—8.3(512A) Organization. Before any new benevolent association shall form or operate in this state, it shall first file with the commissioner for examination and approval one copy of its general plan of organization and operation, an original and two copies of its articles of incorporation, an original and one copy of any bylaws, and two copies of its certificate of membership with application blank. All fees for examination and filing in the office of the commissioner and the secretary of state as prescribed by law must accompany the association's submission.

8.3(1) The plan of organization and operation must set forth in detail any and all fees, dues and assessments to be made against the membership, the intended size and grouping of the membership, the method of member enrollment and procedure for replacement of deceased or left members, the establishment of any reserves or surplus funds, and the intended name and business address of the association. The plan shall also contain a biographical sketch of all organizers and officers and comply with the laws and regulations governing benevolent associations.

8.3(2) If an association is organized or becomes organized under Iowa Code chapter 504A for the purpose of selling or offering for sale stock to the public of this state such offer must be fully disclosed in the plan of organization and if such offer is exempt from registration the specific exemption must be set forth in the plan.

8.3(3) Reserved.

8.3(4) Except where a public stock offer is made, the plan of operation for associations existing prior to the adoption of this regulation may be contained in its bylaws, however, such plan shall be in accordance with the laws and regulations pertaining to such associations.

191—8.4(512A) Membership. Each association shall have one or more groups or units consisting of not more than 1250 members per group or unit who may make voluntary contributions to the association for distribution to the beneficiary of a deceased member or to the members as contributions toward expenses incurred by accident or sickness.

8.4(1) If membership in the association is conditioned upon the payment of benefit assessments levied against the members, such loss or cancellation of membership shall take place only if a member, after being notified by mail of such assessment, has failed to remit a contribution within 30 days from the date of mailing of the benefit assessment notice. The association may thereafter serve notice of cancellation of membership which shall provide that if all delinquencies are not paid within 10 days after mailing of such notice, all benefits of membership shall be fully terminated.

8.4(2) Rescinded, effective April 20, 1983.

191—8.5(512A) Fees, dues and assessments. Benevolent associations may make charges against the membership in the form of benefit assessments, enrollment fees or dues and operational expense fees.

8.5(1) An enrollment fee or dues to cover initial expenses may be charged but such fees or dues shall not exceed $10 per enrollee membership. If two or more enrollees are in one family, the enrollment fee shall not exceed $8 for each person, provided that the family unit enrolls at the same time.

8.5(2) A benefit assessment may be made against the group or unit membership to cover each valid claim presented by a member or the named beneficiary of a deceased member of that unit or group. The benefit portion of the assessment shall not exceed the maximum benefit payable as stated upon the certificate of membership by more than 20 percent of the maximum benefit payable to the claiming member or beneficiary of a member.

8.5(3) In addition to the benefit contribution an expense fee may be added as a separate item to each assessment or as a separate periodical assessment, provided the expense portion of any assessment represents actual costs directly related to the collection and payment of the certificate benefit, and further

provided that said fee is identified as an expense charge. Reasonable directors' fees and salaries of officers shall be considered as expenses to the association.

8.5(4) Any assessment levied against the members of a group or unit, other than any reasonable corporate dividends or undivided profits as declared by the board of directors, shall be considered as trust funds belonging to the members of the group and shall not become the property of the association itself, except for that portion of the assessment or contribution added as a separate item for expenses in the collection and distribution of such fund.

191—8.6(512A) Reserve fund. Any moneys remaining after the payment of a benefit by the association, except the expense contribution and any reasonable corporate dividends or undivided profits, shall be maintained as a reserve fund to be used only for the benefit of the members of the specific group or unit from which it was collected. Such reserve funds shall be used periodically as determined by the board of directors to pay benefits to a claiming member or the beneficiary of a member without making an assessment against the membership of the group or unit.

Any association in existence before January 1, 1967, having presently in use an equally equitable plan for the periodic distribution of the reserve funds, can continue to use such plan provided it is fully disclosed in writing to the commissioner and has been approved by the commissioner for use.

191—8.7(512A) Certificates. In addition to the requirements of Iowa Code section 512A.7 as they concern the membership certificates, said certificates shall also contain sufficient information to inform a member or a member's beneficiary on the proper procedure in the filing of a claim, including any limitations or exclusions affecting the claim.

191—8.8(512A) Beneficiaries. In the application for membership, the applicant may designate a beneficiary or beneficiaries. If no beneficiary is named or the named beneficiary or beneficiaries do not survive the member, the estate shall become the beneficiary.

Each association shall have forms to provide for the change of beneficiary in the event a member wishes to change or add a beneficiary.

191—8.9(512A) Mergers. Should the membership of a group or unit fall below 50 percent of its established size as set forth in the plan of operation, such group or unit shall be merged into another existing group in the association and any funds of the depleted membership group shall become the reserve funds of the group into which it is merged.

If the entire membership of an association falls below 60 percent of its established size as described in its plan of operation, such association must make a bona fide attempt to merge with another such association to protect the interests of the remaining members. Any reserve funds of the merging association shall become the reserve funds of the surviving merged association. If merger attempts are unsuccessful, the association must present a plan of reorganization to the commissioner for approval.

191—8.10(512A) Directors and officers. Each benevolent association shall have at least three persons on its board of directors at all times and shall have more than one person act as corporate officer.

191—8.11(512A) Stockholders. If any benevolent association issues stock, such association shall have its stock owned by more than one stockholder.

191—8.12(512A) Bookkeeping and accounts. Each benevolent association shall maintain a set of books and records in accordance with normally accepted accounting procedures. Such books and records shall be used to supply the information requested in the annual statement provided each year by the insurance commissioner.

These rules are intended to implement Iowa Code chapter 512A.

[Filed November 30, 1967]

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[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

CHAPTER 9
REPORTING REQUIREMENTS ON LICENSES

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

Rescinded IAB 10/2/02, effective 11/6/02

INSURANCE AGENTS

CHAPTER 10
LICENSING OF INSURANCE PRODUCERS

DIVISION I
LICENSING OF INSURANCE PRODUCERS

191—10.1(522B) Purpose and authority.

10.1(1) The purpose of these rules is to set out the requirements, procedures and fees relating to the qualification, licensure and appointment of insurance producers.

10.1(2) These rules are authorized by Iowa Code section 505.8 and are intended to implement Iowa Code chapters 252J, 261 and 522B.

191—10.2(522B) Definitions.

"Appointment" means a notification filed with the division or its designated vendor that an insurer has established an agency relationship with a producer. A company filing such a request must verify that the producer is licensed for the appropriate line(s) of authority.

"Birth month" means the month in which a producer was born.

"Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

"Commissioner" means the Iowa insurance commissioner.

"CSAC" means college student aid commission.

"CSRU" means child support recovery unit.

"Division" means the Iowa insurance division.

"Home state" means the District of Columbia and any state or territory of the United States in which a producer maintains the producer's principal place of residence or principal place of business and is licensed to act as a producer.

"Individual" means a private or natural person, as distinguished from a partnership, corporation or association.

"Insurance" means any of the lines of insurance listed in subrule 10.7(1).

"License" means the division's authorization for a person to act as a producer for the authorized lines of insurance.

"License number" means the National Insurance Producer Registry (NIPR) national producer number (NPN) issued to all licensees whose license records exist in the state producer licensing database (SPLD). For purposes of this definition, "state producer licensing database (SPLD)" means the national database of producers maintained by the National Association of Insurance Commissioners (NAIC), its affiliates or subsidiaries.

"National Insurance Producer Registry" or *"NIPR"* means the nonprofit affiliate of the National Association of Insurance Commissioners (NAIC). The NIPR's Web site is www.NIPR.com.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract provided that the person engaged in that act either sells insurance or obtains insurance for purchasers.

"NIPR Gateway" means the communication network developed and operated by NIPR that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of producer information regarding license applications, license renewals, appointments and terminations.

"Nonresident" means a person whose home state is not Iowa.

"Notification" means a written or electronic communication from a producer to the division.

"Person" means an individual or a business entity.

"Producer" or *"insurance producer"* means a person required to be licensed in this state to sell, solicit or negotiate insurance.

"Producer renewal notice" means an electronic communication issued by the division to inform a producer about license renewal.

"Resident" means a person whose home state is Iowa.

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

"Solicit" or *"solicitation"* means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

"Termination" means that an insurer has ended its agency relationship with a producer.

"Termination for cause" means that an insurer has ended its agency relationship with a producer for one of the reasons set forth in Iowa Code section 522B.11.

"Uniform application" means the National Association of Insurance Commissioners' uniform application for resident and nonresident insurance producer licensing, as it appears on the NAIC Web site.

[**ARC 7836B**, IAB 6/3/09, effective 7/8/09]

191—10.3(522B) Requirement to hold a license.

10.3(1) No person may sell, solicit or negotiate insurance in Iowa until that person has been issued an Iowa producer license.

10.3(2) A person offering to the public, for a fee or commission, to engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages promised under any policy of insurance must be licensed as a producer.

10.3(3) A person shall not advise an Iowa resident to cancel, not renew, or otherwise change an existing insurance policy unless that person holds an Iowa producer license regarding the line of insurance for which the advice is given. This subrule shall not apply to a licensed attorney or certified public accountant who does not sell or solicit insurance.

10.3(4) The license itself does not provide the producer with any authority to represent or commit an insurer.

191—10.4(522B) Licensing of resident producers.

10.4(1) A person whose home state is Iowa and who desires to be licensed as a producer must satisfy the following requirements:

a. Be at least 18 years of age,

b. Have not committed any act that is grounds for denial under subrule 10.20(4).

c. Submit a completed uniform application,

d. Pass an examination in the line of authority sought, and

e. Pay the appropriate producer license fee.

10.4(2) Examinations are conducted by the outside testing service on contract with the division. Applications and fees for examinations and for initial producer licensing will be submitted either to the outside testing service on contract with the division or as directed by the division. Instructions are available at the division's Web site: www.iid.state.ia.us.

10.4(3) Reserved.

10.4(4) Examination results are valid for 90 days after the date of the test. Failure to apply for licensure within 90 days after the examination is passed shall void the examination results.

10.4(5) Amendments to producer licenses shall be done either by an outside vendor or by the division, as directed by the division. Any licensed producer desiring to become licensed in an additional line of authority shall:

a. Submit a completed uniform application form through the NIPR Gateway or as directed by the division, specifying the line(s) of authority requested to be added. Instructions are available at the division's Web site: www.iid.state.ia.us; and

b. For each line of authority requested to be added, pass any required examination.

10.4(6) A producer who holds a personal lines authority can obtain property and casualty lines of authority upon successful completion of the commercial insurance subject examination.

10.4(7) To receive a license for excess and surplus lines, the applicant must have successfully completed the excess and surplus lines examination and also have successfully completed either: (1) the examinations for property and casualty lines of authority; or (2) the examination for personal lines of authority and the commercial insurance subject examination.

10.4(8) To receive a license for the variable products line of authority, the applicant must:

a. Hold an active Iowa insurance license with a life insurance line of authority;

b. Pass the Financial Industry Regulatory Authority (FINRA) examinations necessary to obtain an Iowa securities license; and

c. File an application through the NIPR Gateway or as directed by the division to amend the license to add the variable products line of authority.

10.4(9) The division may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a producer license. If an applicant does not provide the additional information requested by the division within 45 days of receipt of the request, the application will expire and the license fee will not be returned.

191—10.5(522B) Licensing of nonresident producers.

10.5(1) A producer for whom Iowa is not the home state who desires to sell, solicit or negotiate insurance in Iowa must satisfy the following requirements to obtain an Iowa nonresident producer license:

a. Be licensed and in good standing in the home state;

b. Submit a proper request for licensure to the division through the NIPR Gateway; and

c. Pay the appropriate fee.

10.5(2) Any licensed nonresident producer desiring to become licensed in an additional line of authority shall submit to the division using the NIPR Gateway a completed application form specifying the line(s) of authority requested to be added.

10.5(3) A license will not be issued to a nonresident producer if the producer's resident state does not issue licenses to Iowa resident producers applying for nonresident producer licenses in that state or if the producer's resident state restricts Iowa resident producers' nonresident activities in that state.

10.5(4) The division may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a producer license. If an applicant does not provide the additional information requested by the division within 45 days of receipt of the request, the application will expire and the license fee will not be returned.

191—10.6(522B) Issuance of license.

10.6(1) A person who meets the requirements of Iowa Code sections 522B.4 and 522B.5, or section 522B.7, and of rule 10.5(522B), unless otherwise denied licensure pursuant to Iowa Code section 522B.11 or rule 10.20(522B), shall be issued a producer license. A producer license shall remain in effect for an initial term of three years after the last day of the applicant's birth month of the year the license was issued, unless revoked or suspended. A license may be continually renewed pursuant to rule 10.8(522B) as long as the proper fees are paid and home state continuing education requirements are met. A renewal term is three years. If not renewed, a producer license automatically terminates on the last day of the month of the initial or renewal term.

10.6(2) An individual producer whose license has expired may seek reinstatement as set forth in rule 191—10.9(522B).

10.6(3) The license shall contain the producer's name, address, license number, date of issuance, date of expiration, the line(s) of authority held and any other information the division deems necessary. The license number shall be the same as the producer's National Insurance Producer Registry (NIPR) national producer number (NPN).

10.6(4) If the division issues or renews a producer license and subsequently determines that payment for the license or renewal was returned to the division by a bank without payment, or that the credit card

company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the division are paid, at which time the license may be reinstated. The individual may request a hearing within 30 days of receipt of notice by the division that the license was suspended.

191—10.7(522B) License lines of authority. In addition to the lines of authority listed in Iowa Code subsection 522B.6(2), the following lines of authority also are available for issuance in Iowa: crop; surety; and reciprocal (any other line of insurance issued in another state and for which Iowa grants authority to sell, solicit or negotiate in this state).

191—10.8(522B) License renewal.

10.8(1) Upon request by a producer, the division shall electronically transmit a producer renewal notice to a licensed producer at the producer's last-known electronic mail address as it appears in division records. If the division has received notification that the electronic address of record is no longer valid, no renewal notice will be transmitted.

10.8(2) A producer must apply for license renewal within 60 days prior to the expiration date of the license. Failure to apply to renew a license and pay appropriate fees prior to the expiration date of the license will result in expiration of the license.

10.8(3) A producer may submit an electronic mail address to the division as directed by the division.

10.8(4) Resident producer licenses may be renewed electronically through the NIPR Gateway at www.NIPR.com.

10.8(5) Nonresident producer licenses may be renewed only through the NIPR Gateway, or as otherwise directed by the division.

[**ARC 7836B**, IAB 6/3/09, effective 7/8/09]

191—10.9(522B) License reinstatement.

10.9(1) A resident producer may reinstate an expired license up to 12 months after the license expiration date by proving that during the CE term the producer met the CE requirements found in 191—Chapter 11, and by paying a reinstatement fee and license renewal fees. A resident producer who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

10.9(2) A nonresident producer may reinstate an expired license up to 12 months after the expiration date by submitting a request through the NIPR Gateway and by paying a reinstatement fee and license renewal fee. After the 12-month period, a nonresident producer must apply for a new license.

10.9(3) A producer who has surrendered a license for a nondisciplinary reason and stated an intent to exit the insurance business may file a request to reactivate the license. The request must be received at the division within 90 days of the date the license was placed on inactive status. The request will be granted if the former producer is otherwise eligible to receive the license. If the request is not received within 90 days, the producer must apply for a new license.

191—10.10(522B) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

10.10(1) The term "reinstatement" as used in this rule means the reinstatement of a suspended license. The term "reissuance" as used in this rule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter, including but not limited to proceedings pursuant to rules 191—10.21(252J), 191—10.22(261) and 191—10.23(82GA,SF2428). This rule does not apply to the reinstatement of an expired license.

10.10(2) Any producer whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A producer may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding paragraph 10.10(2)*"c"*), revocation, or acceptance of the forfeiture of a license.

10.10(3) All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

10.10(4) An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems desirable, which may include one or more of the types of disciplinary sanctions provided by Iowa Code section 522B.11. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapter 22.

10.10(5) A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

10.10(6) When a producer's license has been suspended for a period of time which extends beyond the producer's license expiration date, the license will terminate at the license expiration date, and the producer must request reinstatement pursuant to subrule 10.10(2). If suspension for a period of time ends prior to the producer's license expiration date, the division shall reinstate the license at the end of the suspension period. The commissioner is not prohibited from bringing an additional immediate action if the producer has engaged in misconduct during the period of suspension.

191—10.11(522B) Temporary licenses. An Iowa resident may apply for a temporary license pursuant to Iowa Code section 522B.10. The applicant should submit a written request to the division which includes the reason for the request and the length of time for which the temporary license is requested. Temporary licenses will be issued for 90 days, with extensions allowed, but in no event for longer than 180 days, pursuant to Iowa Code section 522B.10.

191—10.12(522B) Change in name, address or state of residence.

10.12(1) If a producer's name is changed, the producer must file notification with the division within 30 days of the name change. The notification must include the producer's:

a. Prior name;

b. License number; and

c. New name.

Notification shall be filed through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.12(2) Address change. If a resident or nonresident producer's address is changed, the producer must file notification with the division within 30 days of the address change. The notification must include the producer's:

a. Name;
b. License number;
c. Previous address; and
d. New address. A producer may designate a business address instead of a resident address at the option of the producer.

Notification shall be filed through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.12(3) A nonresident producer who moves from one state to another state or an Iowa resident producer who moves to another state and wishes to retain an Iowa producer license must file a change of address with the division and provide a certification from the new resident state within 30 days of the change of legal residence. No fee or license application is required. If the new resident state is actively participating in the producer database, a letter of certification is not required. A nonresident licensed producer who moves to Iowa and wishes to retain the nonresident's producer license must file a change of address with the division within 90 days of the change of legal residence.

10.12(4) Issuance of an Iowa nonresident producer license is contingent on proper licensure in the nonresident producer's home state. Termination of the producer's resident license will be deemed termination of the Iowa nonresident producer license unless the producer timely files a change of address pursuant to this rule.

10.12(5) If a producer has provided an E-mail address to the division, the division has the option to send information to the producer through the E-mail address rather than through the mail.

191—10.13(522B) Reporting of actions.

10.13(1) A producer shall report to the division any actions required to be reported by Iowa Code section 522B.16.

10.13(2) A producer shall report to the division all CSAC or CSRU actions taken under or in connection with Iowa Code chapter 261 or 252J and all court orders entered in such actions.

10.13(3) Failure to file reports required by this rule is a violation of this chapter and will subject producers to penalty pursuant to rule 191—10.20(522B).

191—10.14(522B) Commissions and referral fees.

10.14(1) An insurance company shall not pay, and a person shall not accept, any commission, service fee, brokerage or other valuable consideration unless the person performing the service held a valid license for the line of insurance for which the service was rendered at the time the service was performed.

10.14(2) A producer may assign commissions to an entity organized for the purpose of operating that producer's insurance business if all of the entity's representatives who personally sell, solicit or negotiate insurance in Iowa are individually licensed as producers under Iowa law.

10.14(3) An insurer or a producer may pay a nominal fee for referrals if the same fee is paid for each referral whether or not the referral results in an insurance transaction.

10.14(4) An insurer or a producer may not charge an additional fee for services that are customarily associated with the sale, solicitation, negotiation and servicing of an insurance policy. This prohibition does not apply to assigned risk and commercial property/casualty policies. Any fees or other charges that are assessed to an insurance consumer must be fully disclosed.

10.14(5) A person who is not engaged in any activities in Iowa that require a producer license in Iowa is not required to maintain an active producer license in order to receive override or hierarchy commissions or to receive renewal commissions earned while the producer was actively engaged in activities that required a producer license.

191—10.15(522B) Appointments.

10.15(1) Insurers are required to file appointments with the division for each producer with which the producer has an agency relationship. The determination of whether an insurer and a producer have an agency relationship will be made by the division based on the totality of the circumstances surrounding the business relationship. Appointments are not issued for business entities.

10.15(2) Insurers shall file and pay for initial appointments using the NIPR Gateway, except that insurers authorized under Iowa Code chapter 518 or 518A shall file appointments directly with the division by arrangement with the division.

10.15(3) The notice of appointment must be filed within 30 days of the date the insurer and producer execute an agency contract or the first insurance application is submitted to the insurer.

10.15(4) Appointment fees are set forth in rule 191—10.26(522B). The division or its designee will electronically transmit a billing statement to insurers authorized under Iowa Code chapter 518 or 518A, and payment is due within 45 days. The division will assess a late fee of $100 for the failure to timely pay appointment billing statements and an additional $500 on or after the forty-sixth day.

10.15(5) The division may adopt special appointment filing procedures to allow an insurer to file one appointment request that will appoint a producer to some or all of the affiliated insurance companies that comprise a holding company.

10.15(6) When a company loses its identity in a new company by merger, acquisition, or otherwise, the new company must contact the licensing bureau to arrange for reappointment of the producers to the remaining company.

10.15(7) Insurance companies are required to file the name, address, and electronic address of a contact person for the company, to whom the billing statements will be sent. Insurance companies are required to notify the division if a there is a change of the person appointed as the contact person or if a change of the address of such contact occurs. If a company fails to notify the division of such a change, the division shall charge the insurance company a $100 fee.

[**ARC 7836B**, IAB 6/3/09, effective 7/8/09]

191—10.16(522B) Appointment renewal.

10.16(1) On or about December 1 of each year, the division or its designee will deliver reminders to insurance companies that appointment renewals are imminent. Appointments shall be renewed electronically via the NIPR Gateway at www.NIPR.com.

10.16(2) On or about January 2 of each year, a list of the producers currently appointed with each insurance company and a billing statement will be provided to each insurance company via the NIPR Gateway. The billing statement may not be altered, amended or used for appointing or terminating producers.

10.16(3) Payment is due on or before March 1.

10.16(4) Failure to pay renewal appointment fees by March 15 will result in termination of a company's appointments. Appointments that are terminated due to nonpayment of renewal fees may be reinstated upon payment of the renewal fee plus a reinstatement fee of $500.

10.16(5) Insurance companies are required to file the name, address, and electronic address of a contact person for the company, to whom the appointment renewals will be sent. Insurance companies are required to notify the division if a change of the address of such contact occurs. If a company fails to notify the division of such a change of address, the division shall charge the insurance company a $100 fee.

[**ARC 7836B**, IAB 6/3/09, effective 7/8/09]

191—10.17(522B) Appointment terminations.

10.17(1) When an insurance company terminates its relationship with a producer, the company shall notify the division using the NIPR Gateway. The termination must be filed within 30 days of the date the insurer terminated its agency relationship with the producer. The company shall also notify the producer that the producer's appointment has been canceled.

10.17(2) There is no fee for the filing of an appointment termination.

10.17(3) The division may adopt special procedures for the filing of termination requests for a group of affiliated insurance companies that comprise a holding company.

10.17(4) When an insurer terminates an appointment for cause pursuant to Iowa Code section 522B.14, the notification of termination may be filed according to subrule 10.17(1). The supporting documents required by Iowa Code section 522B.14 shall be submitted to the division within ten days

of the filing of the notification. The documents shall include a certification by an officer or authorized representative of the insurer.

191—10.18(522B) Licensing of a business entity.

10.18(1) *Application.* A business entity may apply for an Iowa insurance license. For purposes of this rule, upon approval of an application by the division, the business entity shall be classified as a producer and shall be subject to all standards of conduct and reporting requirements applicable to producers.

10.18(2) *Requirements.*

a. To qualify for such a license, the business entity must:

(1) File a completed NAIC uniform business entity application through the NIPR Gateway or as directed by the division. For purposes of this subrule, "uniform business entity application" means the National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities, as the application appears on the NAIC Web site;

(2) Designate one officer, owner, partner, or member of the business entity, which person also is a producer licensed by the division, as the person who will have full responsibility for the conduct of all business transactions of the business entity or of producers affiliated with the business entity;

(3) For a nonresident business entity, submit an appropriate request through the NIPR Gateway; and

(4) Pay the license fee.

b. The designated responsible producer shall maintain an active Iowa producer license. If the license of the designated responsible producer terminates or lapses for any reason, the business entity must supply the division with a substitute designated responsible producer within ten days. If the business entity does not provide a substitute, the division shall terminate the license, and the entity shall submit a new application.

10.18(3) *License term.* A business entity license issued under this rule shall be effective for three years and one month, including the year of application, beginning on the first day of the month of the business entity's formation date and ending with the last day of the month of the business entity's formation date. By arrangement with the division, a business entity may choose a different month for its license term.

10.18(4) *License renewal.* Upon request by a business entity, the division shall electronically transmit a renewal notice to the electronic mail address of the business entity on file with the division on or before the first day of the month preceding the renewal month. The renewal fee must be received by the division or its designated vendor on or before the license expiration date. All business entities must renew their licenses through the NIPR Gateway or as otherwise directed by the division.

10.18(5) *Business address.* Business entities licensed under this rule must maintain a current business address with the division. If a business entity's address is changed, notification from the designated responsible producer must be submitted to the division within 30 days of the address change, stating:

a. Name of the business entity;

b. License number;

c. Previous address; and

d. New address.

The notification may be sent by electronic mail through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.18(6) *Business name.* A business entity licensed under this rule must keep the division informed of its business name. If a business entity changes the name under which it is operating, notification from the designated responsible producer must be submitted to the division within 30 days of the name change. The notification may be sent by electronic mail to producer.licensing@iid.state.ia.us, or through the NIPR Gateway, if available.

[**ARC 7836B**, IAB 6/3/09, effective 7/8/09]

191—10.19(522B) Use of senior-specific certifications and professional designations in the sale of life insurance and annuities.

10.19(1) *Purpose.* The purpose of this rule is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

10.19(2) *Scope.* This rule shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by a producer.

10.19(3) *Authority.*

a. This rule is promulgated under the authority of Iowa Code chapters 507B and 522B.

b. Nothing in this rule shall limit the division's authority to enforce existing provisions of law.

10.19(4) *Prohibited uses of senior-specific certifications and professional designations.*

a. It is an unfair and deceptive act or practice in the business of insurance within the meaning of Iowa Code chapter 507B for a producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

b. The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(1) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(2) Use of a nonexistent or self-conferred certification or professional designation;

(3) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the producer using the certification or designation does not have; and

(4) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

1. Is primarily engaged in the business of instruction in sales or marketing;

2. Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;

3. Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

4. Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

c. There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for purposes of subparagraph 10.19(4)*"b"*(4) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the organization or the certification or designation in question has been accredited by:

(1) The American National Standards Institute (ANSI);

(2) The National Commission for Certifying Agencies; or

(3) Any organization that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

d. In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

(1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

e. Financial services regulatory agency.

(1) For purposes of this rule, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

1. Indicates seniority or standing within the organization; or
2. Specifies an individual's area of specialization within the organization.

(2) For purposes of paragraph 10.19(4)*"e,"* "financial services regulatory agency" includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

f. Effective date. This rule shall become effective January 1, 2009.

191—10.20(522B) Violations and penalties.

10.20(1) A producer who sells, solicits or negotiates insurance, directly or indirectly, in violation of this chapter shall be deemed to be in violation of Iowa Code section 522B.2 and subject to the penalties provided in Iowa Code section 522B.17.

10.20(2) A person who sells, solicits or negotiates insurance, directly or indirectly, who is not properly licensed as a producer is subject to the penalties provided in Iowa Code chapter 507A and Iowa Code section 522B.17.

10.20(3) Any company or company representative who aids and abets a producer in the above-described violation shall be deemed to be in violation of Iowa Code section 522B.2 and subject to the penalties provided in Iowa Code section 522B.17.

10.20(4) The commissioner may place on probation, suspend, revoke, or refuse to issue or renew a producer's license or may levy a civil penalty, in accordance with Iowa Code section 522B.17 or any combination of actions, for any action listed in Iowa Code section 522B.11 and any one or more of the following causes:

a. Submitting to the division or to the outside testing service on contract with the division a check which is returned to the division by a bank without payment, or submitting a payment to the division by credit card which the credit card company does not approve, or canceling or refusing amounts charged to a credit card by the outside testing service on contract with the division where services were received by the producer;

b. Failing to report any administrative action or criminal prosecution taken against the producer or failure to report the termination of a resident producer license;

c. Acting as a producer through persons not licensed as producers; or

d. Taking any action to circumvent the spirit of these rules and the Iowa insurance statutes or any other action that shows noncompliance with the requirements of Iowa Code chapter 522B or these rules.

10.20(5) If a producer fails to provide to the division any notification required either by Iowa Code chapter 522B or by this chapter, including but not limited to notification of a change of address, notification of change of name, or notification of administrative criminal action as required by rules 191—10.12(522B) and 191—10.13(522B), within the required time, the producer shall pay a late fee of $100. A business entity that fails to make a notification to the division as required by rule 191—10.18(522B) within the required time shall pay a late fee of $100.

10.20(6) In the event that the division denies a request to renew a producer license or denies an application for a producer license, the commissioner shall provide written notification to the producer or applicant of the denial or failure to renew, including the reason therefor. The producer or applicant may request a hearing within 30 days of receipt of the notice to determine the reasonableness of the division's action. The hearing shall be held within 30 days of the date of the receipt of the written demand by the applicant and shall be held pursuant to 191—Chapter 3.

10.20(7) The commissioner may suspend, revoke, or refuse to issue the license of a business entity if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the entity and the violation was neither reported to the insurance division nor was corrective action taken.

191—10.21(252J) Suspension for failure to pay child support.

10.21(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the producer's last-known address by regular mail.

10.21(2) The notice shall contain the following items:

a. A statement that the commissioner intends to suspend the producer's application, request for renewal or current insurance license in 30 days.

b. A statement that the producer must contact the CSRU to request a withdrawal of the certificate of noncompliance;

c. A statement that the producer's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;

d. A statement that the producer does not have a right to a hearing before the division, but that the producer may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;

e. A statement that the filing of an application with the district court will stay the proceedings of the division;

f. A copy of the certificate of noncompliance.

10.21(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the division is notified by the district court of the resolution of the application.

10.21(4) If the division does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the division shall suspend the producer's application, request for renewal or current license 30 days after the notice is issued.

10.21(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt and the named producer shall be notified that the proceedings have been halted. If the producer's license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with division rules. All fees required for license renewal or license reinstatement must be paid by producers and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to this subrule.

191—10.22(261) Suspension for failure to pay student loan.

10.22(1) The division shall deny the issuance or renewal of a producer license upon receipt of a certificate of noncompliance from the college student aid commission (CSAC) according to the procedures set forth in Iowa Code sections 261.126 and 261.127. In addition to the procedures contained in those sections, this rule shall apply.

10.22(2) Upon receipt of a certificate of noncompliance from the CSAC according to the procedures set forth in Iowa Code sections 261.126 and 261.127, the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current license will be suspended 60 days after the date of the notice. Notice shall be sent to the producer's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed producer may accept service personally or through authorized counsel.

10.22(3) The notice shall contain the following items:

a. A statement that the commissioner intends to suspend the producer's application, request for renewal or current insurance license in 60 days;

b. A statement that the producer must contact the CSAC to request a withdrawal of the certificate of noncompliance;

c. A statement that the producer's application, request for renewal or current producer license will be suspended if the certificate of noncompliance is not withdrawn or, if the current license is on suspension, a statement that the producer's current producer license will be revoked;

d. A statement that the producer does not have a right to a hearing before the division, but that the producer may file an application for a hearing in district court pursuant to Iowa Code section 261.127;

e. A statement that the filing of an application with the district court will stay the proceedings of the division;

f. A copy of the certificate of noncompliance.

10.22(4) The effective date of revocation or suspension of a producer license, as specified in the notice required by Iowa Code section 261.126, shall be 60 days following service of the notice upon the applicant or registrant.

10.22(5) In the event an applicant or licensed producer timely files a district court action following service of a division notice pursuant to Iowa Code section 261.127, the division's suspension proceedings will be stayed until the division is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the division to proceed, the division shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a producer license, the division shall count the number of days before the action was filed and the number of days after the court disposed of the action.

10.22(6) If the division does not receive a withdrawal of the certificate of noncompliance from the CSAC or a notice from a clerk of court that an application for hearing has been filed, the division shall suspend the producer's application, request for renewal or current producer license 60 days after the notice is issued.

10.22(7) Upon receipt of a withdrawal of the certificate of noncompliance from the CSAC, suspension proceedings shall halt and the named producer shall be notified that the proceedings have been halted. If the producer's insurance license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with division rules. All fees required for license renewal or license reinstatement must be paid by producers and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code section 261.126.

10.22(8) The division shall notify the producer in writing through regular first-class mail, or such other means as the division deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a producer license, and shall similarly notify the producer when the producer license is reinstated following the division's receipt of a withdrawal of the certificate of noncompliance.

10.22(9) Notwithstanding any statutory confidentiality provision, the division may share information with the CSAC for the sole purpose of identifying producers subject to enforcement under Iowa Code chapter 261.

191—10.23(82GA,SF2428) Suspension for failure to pay state debt.

10.23(1) The commissioner shall deny the issuance or renewal of a producer license upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures in 2008 Iowa Acts, Senate File 2428. In addition to the procedures set forth in 2008 Iowa Acts, Senate File 2428, this rule shall apply.

10.23(2) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures set forth in 2008 Iowa Acts, Senate File 2428, the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current producer license will be suspended 60 days after the date of the notice. Notice shall be sent to the producer's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed producer may accept service personally or through authorized counsel.

10.23(3) Pursuant to 2008 Iowa Acts, Senate File 2428, section 14, the notice shall contain the following items:

a. A statement that the commissioner intends to suspend the producer's application, request for renewal or current producer license in 60 days;

b. A statement that the producer must contact the centralized collection unit of the department of revenue to schedule a conference or to otherwise obtain a withdrawal of the certificate of noncompliance;

c. A statement that the producer's application, request for renewal or current producer license will be suspended or denied if the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue within 60 days of the issuance of notice under this rule; or, if the current producer license is on suspension, a statement that the producer's current producer license will be revoked;

d. A statement that the producer does not have a right to a hearing before the commissioner, but that the producer may file an application for a hearing in district court pursuant to 2008 Iowa Acts, Senate File 2428, section 15;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

10.23(4) Producers shall keep the commissioner informed of all court actions and all actions taken by the centralized collection unit of the department of revenue under or in connection with 2008 Iowa Acts, Senate File 2428; and producers shall provide to the commissioner, within seven days of filing or issuance, copies of all applications filed with the district court pursuant to 2008 Iowa Acts, Senate File 2428, section 15, of all court orders entered in such actions, and of all withdrawals of certificates of noncompliance by the centralized collection unit of the department of revenue.

10.23(5) The effective date of revocation or suspension of a producer license, as specified in the notice required by 2008 Iowa Acts, Senate File 2428, section 14, and subrule 10.23(2), shall be 60 days following service of the notice upon the applicant or producer.

10.23(6) In the event an applicant or licensed producer timely files a district court action following service of a notice by the commissioner pursuant to 2008 Iowa Acts, Senate File 2428, section 15, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a producer license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

10.23(7) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the producer's application, request for renewal or current producer license 60 days after the notice is issued.

10.23(8) Upon receipt of a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue, suspension proceedings shall halt, and the named producer shall be notified that the proceedings have been halted. If the producer's license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the producer, and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to 2008 Iowa Acts, Senate File 2428.

10.23(9) The commissioner shall notify the producer in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a producer license, and shall similarly notify the producer when the producer license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

10.23(10) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the centralized collection unit of the department of revenue for the sole purpose of identifying producers subject to enforcement under 2008 Iowa Acts, Senate File 2428.

191—10.24(522B) Administration of examinations.

10.24(1) The division will enter into a contractual relationship with an outside testing service, in compliance with Iowa law, to provide the licensing examinations for all lines of authority which require an examination.

10.24(2) The outside testing service will administer all examinations for license applicants.

10.24(3) Any contract to implement subrule 10.24(1) shall require the outside testing service to:

a. Update, on a continual basis, the licensing examinations;

b. Ensure that the examinations are job-related;

c. Adequately inform the applicants of the procedures and requirements for taking the licensing examinations;

d. Prepare and administer examinations for all lines listed in Iowa Code subsection 522B.6(2) and rule 191—10.7(522B), except variable contracts; and

e. Conform to division guidelines and Iowa law, and report to the division on at least a quarterly basis.

191—10.25(522B) Forms. An original of each form necessary for the producer's licensure, appointment and termination may be downloaded from the NAIC Web site, and the division's Web site (www.iid.state.ia.us) will provide a link to that site. Exact, readable, high-quality copies may be made therefrom. A self-addressed, stamped envelope must be submitted with each request.

191—10.26(522B) Fees.

10.26(1) Fees may be paid by check or credit card.

10.26(2) The fee for an examination shall be set by the outside testing service under contract with the division and approved by the division.

10.26(3) The fee for issuance or renewal of a producer license is $50 for three years.

10.26(4) The fee for issuance or renewal of a business entity license is $50 for three years.

10.26(5) The fee for reinstatement of a producer license is a total of the renewal fee plus $100.

10.26(6) The fee for an appointment or the renewal of an appointment is $5 for each producer appointed to a domestic company. The fee for appointment or renewal of each producer appointed to a foreign company is the fee charged by the state of domicile.

10.26(7) The division may charge a reasonable fee for the compilation and production of producer licensing records.

These rules are intended to implement Iowa Code chapters 252J, 261, and 522B and 2008 Iowa Acts, Senate File 2428.

191—10.27 to **10.50** Reserved.

DIVISION II
LICENSING OF CAR RENTAL COMPANIES AND EMPLOYEES
(Effective March 15, 2000)

191—10.51(522A) Purpose. The purpose of these rules is to govern the qualifications and procedures for the licensing of car rental companies and counter employees and to set out the requirements, procedures and fees relating to the qualification and licensure of car rental companies and counter employees.

191—10.52(522A) Definitions.

"Counter employee" means a person at least 18 years of age employed by a rental company that offers the products described in this chapter.

"Counter Employee Application" means the form used by an individual to apply for a counter employee license.

"Division" means the Iowa insurance division.

"Filed" means received at the Iowa insurance division.

"Limited Licensee Application" means the form used by a rental company to apply for a limited license.

"Rental company" means any person or entity in the business of primarily providing vehicles intended for the private transportation of passengers to the public under a rental agreement for a period not to exceed 90 days.

"Vehicle" means a motor vehicle under Iowa Code section 321.1 used for the private transportation of passengers, including passenger vans, minivans and sport utility vehicles or used for the transportation of cargo with a gross vehicle weight of less than 26,001 pounds and not requiring the operator to possess a commercial driver's license, including cargo vans, pickup trucks and trucks.

191—10.53(522A) Requirement to hold a license.

10.53(1) A rental company that desires to offer or sell insurance in connection with the rental of a vehicle must file an application with the division and receive a license as a limited licensee.

10.53(2) A counter employee who desires to offer or sell insurance products must file an application with the division and receive a license as a counter employee.

191—10.54(522A) Limited licensee application process.

10.54(1) To obtain a limited licensee license, a person or entity must file a complete limited licensee license application with the division and pay a fee of $50 for a three-year license.

10.54(2) If the application is approved, the division will issue a limited licensee license.

191—10.55(522A) Counter employee licenses.

10.55(1) A person may not obtain a counter employee license unless that person is employed by a limited licensee.

10.55(2) To obtain a counter employee license, a person must file with the division a completed counter employee license application.

10.55(3) All persons who desire to obtain a counter employee license must first successfully complete an examination.

10.55(4) Examinations shall be administered by the limited licensee that employs the counter employee.

10.55(5) If the application is approved, the division will issue a three-year counter employee license. Applications are deemed approved if not disapproved by the division within 30 days of receipt at the division.

10.55(6) The counter employee license will automatically terminate when the counter employee ceases employment with a limited licensee.

191—10.56(522A) Duties of limited licensees.

10.56(1) A limited licensee is responsible for the training, examination and payment of license fees for all persons who desire to obtain a counter employee license with the limited licensee.

10.56(2) A limited licensee must obtain and administer an examination for all counter employee candidates. The content of the examination and the manner of its administration must be approved by the division.

10.56(3) The limited licensee must develop a system for examination content security.

10.56(4) The limited licensee must administer the counter employee examination under controlled conditions, approved by the division, that ensure that each candidate completes the examination without outside assistance or interference.

10.56(5) The limited licensee must notify the division of the termination of employment of any of its licensed counter employees. The limited licensee must file reports of terminations semiannually on July 1 and on January 1.

191—10.57(522A) License renewal.

10.57(1) All limited licensee and counter employee licenses will be issued with an expiration date of December 31 and must be renewed triennially.

10.57(2) A single renewal form for use in renewing the limited licensee's license and the licenses of all of its counter employees will be mailed to the limited licensee at its last-known address as shown on division records.

10.57(3) The limited licensee must complete and return the renewal form to the division on or before December 31 of the renewal year or all licenses listed on the renewal form will expire.

10.57(4) The fee for renewal of a limited licensee license is $50 and the fee to renew each individual counter employee license is $50.

191—10.58(522A) Limitation on fees. A limited licensee will not be required to pay more than $1,000 in license or renewal fees in any one calendar year.

191—10.59(522A) Change in name or address.

10.59(1) Limited licensees must file written notification with the division of a change in name or address within 30 days of the change. This requirement applies to any change in any locations at which the limited licensee is doing business.

10.59(2) Limited licensees must file written notification with the division of a change in name or address of licensed counter employees. If the change of name is by a court order, a copy of the order must be included with the request. The limited licensee must file reports of name and address changes semiannually on July 1 and on January 1.

191—10.60(522A) Violations and penalties.

10.60(1) A rental company or counter employee that sells insurance in violation of this chapter shall be deemed to be in violation of Iowa Code Supplement chapter 522A and subject to the penalties provided in Iowa Code Supplement section 522A.3.

10.60(2) A limited licensee or licensed counter employee who commits an unfair or deceptive trade practice in violation of Iowa Code chapter 507B, or in violation of administrative rules adopted which implement that chapter, is subject to the penalties provided for in Iowa Code chapter 507B.

Rules 191—10.51(522A) to 191—10.60(522A) are intended to implement Iowa Code Supplement chapter 522A.

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◊ Two or more ARCs

CHAPTER 11
CONTINUING EDUCATION FOR INSURANCE PRODUCERS

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

191—11.1(505,522B) Statutory authority—purpose—applicability.

11.1(1) These rules are adopted pursuant to the general rule-making authority of the insurance commissioner in Iowa Code chapters 505 and 522B to establish continuing education requirements for resident and nonresident insurance producers.

11.1(2) The purpose of these rules is to establish requirements by prescribing:

a. The minimum number of continuing education credits that an insurance producer must complete;

b. The procedure and standards that the division will utilize in the approval of continuing education providers and courses;

c. The procedure for establishing that the required continuing education has been completed; and

d. Enforcement criteria and guidelines.

11.1(3) These rules do not apply to:

a. A nonresident producer who resides in a state or district having a continuing education (CE) requirement for insurance producers.

b. A resident producer who holds qualification in one of the following lines of authority: surety; or credit life, accident and health insurance.

c. Licensed attorneys who are also producers who submit proof of completion of continuing legal education for the appropriate calendar years during the CE term, pay the continuing education fee set forth in subrule 11.14(1) and otherwise comply with the producer license renewal procedures set forth in 191—Chapter 10.

d. A producer who serves full-time in the armed forces of the United States of America on active duty during a substantial part of the CE term and who submits evidence of such service.

e. A resident producer who holds qualification only for a crop insurance line of authority and who complies with subrule 11.3(8).

191—11.2(505,522B) Definitions.

"Approved subject" or *"approved course"* means any educational presentation which has been approved by the division.

"Attendance record" means a record on which a CE provider requires attendees of a CE course to sign in at the time of entrance to the course.

"CE" means continuing education as defined in Iowa Code chapter 522B.

"CE provider" means any individual or entity that is approved to offer continuing education courses in Iowa.

"CE term" means the period of time that begins either on the date when a new producer's insurance license is issued or on the date after the expiration date of an existing producer's license and that ends on the following license expiration date.

"Credit" means continuing education credit. One credit is 50 minutes of instruction or reading material in an acceptable topic.

"License" means the division's authorization for a person to act as an insurance producer for the authorized lines of insurance.

"National Insurance Producer Registry" or *"NIPR"* means the nonprofit affiliate of the National Association of Insurance Commissioners (NAIC). Its Web site is www.licenseregistry.com.

"NIPR Gateway" means the communication network developed and operated by NIPR that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of producer information regarding license applications, license renewals, appointments and terminations.

"Proctored" or *"independently proctored"* means the supervision by a CE provider or disinterested third party over the conduct of a producer while that producer is completing an examination that is part of a self-study CE course.

"Producer" or *"insurance producer"* means a person required to be licensed in this state to sell, solicit or negotiate insurance.

"Resident" means a person residing permanently in Iowa.

"Roster" means a listing of all licensed attendees at an approved course and includes the Iowa course number, the National Insurance Producer Registry (NIPR) National Producer Number (NPN), the date the course was completed, and the actual number of credits earned by each producer.

"Self-study course" means an educational program that consists of a self-study manual and comprehensive examination. A self-study course may be an on-line course.

[**ARC 7662B**, IAB 3/25/09, effective 4/29/09]

191—11.3(505,522B) Continuing education requirements for producers.

11.3(1) Every licensed resident producer must complete a minimum of 36 credits for each CE term in courses approved by the division. Three of these credits must be in the subject of ethics. By the end of the last business day of the producer's CE term, the division must receive from the producer proof of completion of CE courses and payment of the CE fee.

11.3(2) An instructor of an approved subject is entitled to the same credit as a student completing that subject and may receive such credit once during a CE term.

11.3(3) A producer cannot carry over CE credits earned in excess of the producer's CE term requirements from one CE term to the next.

11.3(4) A producer may receive CE credit for self-study courses. A self-study course is considered completed when the examination is received by the CE provider.

a. A producer may receive CE credit for self-study courses that are part of a recognized national designation program as described in subrule 11.5(5).

b. A producer may receive up to 18 CE credits for self-study courses during a CE term that do not meet the definition of paragraph *"a"* if the producer:

(1) Submits an affidavit to the CE provider stating that the examination was independently proctored and was completed without any outside assistance, and

(2) Correctly answers at least 70 percent of the questions presented.

11.3(5) A producer may not receive CE credit for courses taken prior to the issuance of an initial license.

11.3(6) A producer cannot receive CE credit for the same course twice in one CE term. A producer cannot receive CE credit both for the classroom portion and for the examination portion of a national designation program as defined in subrule 11.5(5).

11.3(7) A producer may elect to comply with the CE requirements by taking and passing the appropriate licensing examination for each qualification held by the producer.

a. A producer who holds property and casualty lines of authority must successfully complete the commercial insurance subject examination.

b. A producer who holds an excess and surplus line of authority must successfully complete the examination for the excess and surplus line of authority and the commercial insurance subject examination.

11.3(8) For a resident producer who holds qualification only for a crop insurance line of authority and who is requesting renewal of a producer license on or after January 1, 2010, the producer must be able to demonstrate the following each time renewal of a license is requested:

a. The producer has completed all training and continuing education requirements imposed by the federal Risk Management Association, if any; and

b. The producer has completed 18 credits of continuing education, 3 of which must be in the area of ethics, except that a producer who is requesting renewal of a producer license during 2010 must demonstrate that the producer has completed 9 credits of continuing education, 3 of which must be in the area of ethics.

191—11.4(505,522B) Proof of completion of continuing education requirements.

11.4(1) *Producer duties.*

a. Producers are required to demonstrate compliance with the CE requirements at the time of license renewal. Procedures for completing the license renewal process are outlined in 191—Chapter 10.

b. Producers are required to maintain a record of all CE courses completed by keeping the original certificates of completion for four years after the end of the year of attendance.

11.4(2) *Insurer duties regarding federal flood insurance.* An insurer authorized to do business in Iowa shall demonstrate to the division, upon the division's request, that producers appointed by the insurer have complied with all continuing education guidelines as established by the National Flood Insurance Program (NFIP).

191—11.5(505,522B) Course approval.

11.5(1) To qualify for approval a course must be designed to expand technical insurance skills and knowledge obtained prior to initial licensure or to develop new and relevant skills and knowledge.

11.5(2) Any approved active CE provider shall submit a request for approval of any course, program of study, or subject for continuing education credit to the division on an NAIC uniform form. If an outside vendor is retained by the division for course reviews, requests for approval shall be filed directly with the vendor.

11.5(3) Requests for course approval which do not include all required information will be returned as incomplete.

11.5(4) Except as provided in subrule 11.5(5), requests for approval shall be submitted at least 30 days prior to the beginning of the course. A request for renewal of a previously approved course shall be submitted at least 30 days prior to the end of the 24-month approval period. Requests received later may be disapproved.

11.5(5) A request for approval of any self-study course that is part of a recognized national designation program may be filed within 60 days after the course is completed. This course will be reviewed and may be approved for up to the number of credits awarded for passage of the national examination in topics that are otherwise approvable under these rules. This subrule applies only to national designation programs such as AAI, ARM, CIC, CEBS, ChFC, CFP, CLU, CPCU, FLMI, LUTCF, RHU and similar courses as determined by the division.

11.5(6) An insurance producer who attends a classroom course offered by a college, university or governmental agency that has not been approved by the division may make application for approval of the course for CE credit. The application must be filed within 60 days of attendance at the course and must contain sufficient materials to allow for a thorough evaluation of the course content and instructor qualifications. To be eligible for CE credit, the course must meet all division guidelines for course approval. All course review fees must be paid by the producer.

11.5(7) A CE course must be offered for a minimum of one credit. Fractional credits will not be awarded. The total credit which may be awarded for a CE course is limited to 36 credits, except that credit for a self-study course as defined in 11.3(4)*"b"* shall be limited to 18 CE credits.

11.5(8) Notification will be sent to the CE provider indicating approval or disapproval. Approved courses will be assigned a course number.

11.5(9) The division may deem the approval of a CE course by another state's insurance division as adequate evidence that a course is eligible for approval in Iowa and may award the same number of credits for the course awarded by the other state. The CE provider must submit the NAIC uniform form demonstrating the other state's approval of the CE course.

11.5(10) Within 30 days of course approval, CE providers shall inform the division or its vendor, as directed by the division, of the dates and locations that the course will be offered. Failure to timely file the dates and locations will subject the CE provider to penalty and suspension or rescission of course approval.

11.5(11) CE courses approved by the division may be offered for a 24-month period following the date of approval.

191—11.6(505,522B) Topic guidelines.

11.6(1) The following course topics are examples of subjects that will qualify for approval:

1. Rating;
2. Tax laws (specifically related to insurance);
3. Policy contents;
4. Proper uses of products;
5. Ethics;
6. Risk management;
7. Iowa insurance laws and administrative rules;
8. Technical information related to the insurance license;
9. Errors and omissions;
10. Estate planning/taxation;
11. Wills and trusts; and
12. Financial planning.

11.6(2) The following course topics are examples of subjects that will not qualify for approval:

1. Sales;
2. Motivation;
3. Prospecting;
4. Psychology;
5. Communication skills;
6. Prelicense training;
7. Supportive office skills (e.g., typing, filing, computers);
8. Personnel management;
9. Recruiting; and
10. Other subjects not related to the insurance license.

191—11.7(505,522B) CE course renewal. Prior to expiration of the 24-month approval period, a CE provider must apply for renewal of each course with the division or its outside vendor. If a CE provider makes a substantial change to the content of a previously approved course, that course will not be eligible for renewal and must be submitted for a complete review.

191—11.8(505,522B) Appeals. A CE provider may appeal the amount of CE credit awarded by the division for a course. An appeal must be made in writing to the division within 30 days of the receipt by the CE provider of the notice of CE credit awarded for the course. If the division retains an outside vendor for course reviews, a CE provider must first complete an appeal process with the vendor before filing an appeal with the division.

191—11.9(505,522B) CE provider approval.

11.9(1) Any school, insurer, industry association or other organization intending to provide a course, program of study, or subject for continuing education credit must submit an application on a form or in a format prescribed by the division to become an approved CE provider.

11.9(2) To qualify for approval, a CE provider must demonstrate financial and organizational stability and must agree to comply with the administrative and regulatory constraints set forth by the division.

11.9(3) CE provider approval is valid for 24 months.

11.9(4) A CE provider must complete the renewal process to be eligible to continue serving as a CE provider. Failure to complete the renewal process will result in the expiration of the CE provider's approval and all previously approved courses.

11.9(5) If an outside vendor is retained by the division for CE provider reviews, requests for approval will be filed directly with the vendor.

191—11.10(505,522B) CE provider's responsibilities.

11.10(1) A CE provider must ensure that each classroom course is conducted by a qualified and competent instructor.

11.10(2) A CE provider shall obtain and maintain an attendance record for each course for at least four years from the end of the year in which the course is offered. Upon request by the division, a CE provider must submit copies of attendance records.

11.10(3) A CE provider of an approved course is responsible for both the attendance of the students and their attention. A CE provider must refuse to award CE credit for time periods when the student was absent.

11.10(4) A CE provider must verify that each examination submitted for a self-study course contains an affidavit following the NAIC CE guidelines from the producer that the examination was independently proctored and that the examination was completed without any outside assistance. A CE provider must refuse to award CE credit to producers who fail to submit a properly completed examination or who fail to correctly answer at least 70 percent of the questions on the examination.

11.10(5) Upon request by the division, a CE provider shall videotape a course and such recording shall be promptly submitted to the division.

11.10(6) Upon request by the division, a CE provider must provide a copy of all course materials.

11.10(7) If an approved course is canceled, a CE provider must notify the division, or its outside vendor, and registrants at least 48 hours prior to the course date.

11.10(8) CE providers must submit rosters of all course attendees to the division's outside vendor. These reports must be received at the division by the tenth day of the month following the month in which the course is completed. Rosters shall be submitted electronically in a manner prescribed by the division.

11.10(9) Once a course is completed, the CE provider shall issue a certificate of completion to each person who satisfactorily completes a course. The certificate must be issued within 20 days of course completion and must be signed by either the course instructor or the CE provider's authorized representative. The certificate of completion used by the CE provider must be in a form or format prescribed by the division.

11.10(10) CE providers must report to the division any disciplinary action taken against that CE provider by another state licensing authority.

191—11.11(505,522B) Prohibited conduct—CE providers.

11.11(1) CE providers shall not:

a. Advertise, prior to approval, that a course is approved;

b. Prepare and distribute certificates of completion before the course has been conducted;

c. Issue inaccurate or incomplete certificates of completion;

d. Refuse to issue certificates of completion to any participant who satisfactorily completes an approved course, except when subrule 11.10(3) or subrule 11.10(4) applies.

11.11(2) The division may revoke the approval of a continuing education provider or may discipline a continuing education provider, upon a finding that the CE provider:

a. Committed any one or more of the actions prohibited in subrule 11.11(1);

b. Failed to perform any duties required by these rules; or

c. Committed any other action inconsistent with these rules.

11.11(3) If the division finds that a CE provider has violated Iowa laws or these rules, the division shall give written notification to the CE provider of the alleged improper conduct and any discipline or sanction imposed. The CE provider may make a written request for a hearing within 30 days of receipt of the notice. The hearing shall be held within 30 days of the division's receipt of the written demand by the CE provider unless the parties agree to a later hearing date. The hearing shall be conducted pursuant to 191—Chapter 3.

11.11(4) A fine may be imposed against a CE provider if the commissioner finds, after hearing, that the CE provider knew or should have known that it was in violation of this chapter. The division may take any one or more of the following actions upon a finding of a violation of this rule:

a. Require the CE provider to pay a fine not to exceed $1,000 per violation;

b. Require the CE provider to refund the course admission fee to all participants;

c. Require the CE provider to provide a suitable course to replace the course that was found in violation;

d. Withdraw the approval of courses sponsored by such CE provider; or

e. Take other disciplinary action permitted by statute.

191—11.12(505,522B) Outside vendor. The division may enter into a contractual arrangement with a qualified outside vendor to assist the division with any or all continuing education services. Fees charged by the outside vendor will be subject to division approval and will be paid by the CE provider. Course approval fees are nonrefundable.

191—11.13(505,522B) CE course audits. The division may audit any CE course. The cost of the audit will be charged to the CE provider. Any discrepancies between the materials submitted for approval to the division and the content found at the audit, or any evidence of noncompliance with these rules, may subject the CE provider or instructor to administrative sanctions, including imposition of fines. Governmental bodies, such as community colleges and universities, shall not be charged for the cost of an audit.

191—11.14(505,522B) Fees and costs.

11.14(1) The fees for approval and renewal of CE providers, CE courses and registration of instructors shall be set by the outside vendor retained by the division and are subject to approval by the division.

11.14(2) The division may charge a fee for other services.

These rules are intended to implement Iowa Code chapters 505 and 522B.

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CHAPTER 12
PORT OF ENTRY REQUIREMENTS

191—12.1(508,515) Purpose. The purpose of this chapter is to specify what requirements an alien insurer (one domiciled outside of the United States) must comply with to be considered as a domestic insurer of this state under port of entry authority. An alien insurer may hold this status only after compliance with all of the requirements of this chapter and approval by the commissioner for this status.

191—12.2(508,515) Trust and other admission requirements. The insurer must establish a trust account with a financial institution meeting the requirements of rule 191—32.4(508) or other financial institution approved by the commissioner. The following requirements for the account exist:

12.2(1) The minimum amount of assets to be held in trust must equal the total United States liabilities plus the amount of surplus determined pursuant to rule 12.4(508,515). The insurer will submit a detailed plan for future business activities in the United States and a financial statement of its operations on a worldwide basis with the application for port of entry authority. This worldwide financial statement, which must also be submitted annually thereafter, shall be adjusted to reflect the National Association of Insurance Commissioners (NAIC) statement format to ensure sufficient consistency to be comprehensible and usable by supervisors in the United States. Thereafter, once port of entry status has been granted, a statement in the form prescribed in Iowa Code chapter 508 or 515 shall be filed in the same manner as by domestic insurers for all business written in the United States.

12.2(2) The form of the trust agreement must be submitted to the commissioner in advance for approval as part of the admission process for the alien insurer. The agreement shall be in the form set forth in rule 191—32.3(508). The "minimum aggregate value of securities" for this purpose shall be specified by the commissioner. The commissioner may from time to time require additions or changes in the agreement as are deemed necessary for protection of policyholders in the United States.

191—12.3(508,515) Examination and preferred supervision. A "desk" or on-site examination shall be conducted of the alien insurer seeking domestic insurer status. Reasonable expenses of the examination shall be paid by the insurer directly to the insurance division's revolving fund. The commissioner may designate certain insurance regulatory or supervisory authorities, bodies, or officials outside the United States as preferred supervisors. Prior to designation, the commissioner shall ensure that credible regulatory supervision will be provided by the other supervisor. Preferred supervisors shall maintain membership in the International Insurance Regulators Association. A list of preferred supervisors shall be maintained by the commissioner.

191—12.4(508,515) Surplus required. In the event preferred supervision exists for an alien/domestic insurer, the surplus required shall be $5 million. If preferred supervision has not been determined to exist, the commissioner may require such additional amount of surplus as the commissioner deems appropriate.

191—12.5(508,515) Investments. The assets of the trust pursuant to rule 12.2(508,515) shall meet the same investment requirements as are imposed upon domestic insurers under Iowa Code chapter 511 or 515. If chapter 511 is applicable, and the concept of "legal reserve" is not meaningful with regard to the insurer, then "legal reserve" shall mean admitted assets of the insurer.

These rules are intended to implement Iowa Code sections 508.10 and 515.70.

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CHAPTER 13
Reserved

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.

191—14.2(507B) Authority. These rules are issued based upon the authority granted the commissioner under Iowa Code section 507B.4.

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.

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 14.11(507B) who certifies to 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.

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 all policy forms being actively marketed on February 1, 1997, the insurer shall identify in writing those forms and whether or not an illustration will be used with them. For policy forms filed after February 1, 1997, the identification shall be made at the time of filing. Any previous identification may be changed by notice to the commissioner.

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 furnished 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 furnished 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 more than the minimum premium necessary to provide pure death benefit protection. In addition, the insurer shall make a basic illustration available to any nonterm group life enrollee who requests it.

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.

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 any nonguaranteed 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.

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.

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.

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 (e.g., 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.

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"* above;

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:

1. Annually for all policy forms for which illustrations are used; and
2. 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 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.

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.

191—14.13(507B) Separability. 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.

191—14.14(507B) Effective date. These rules shall become effective February 1, 1997, and shall apply to policies sold on or after the effective date.

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

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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.

191—15.2(507B) Definitions.

"Advertisement" for the purpose of these rules shall be 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 on-line networks and similar displays; descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and sales talks, presentations, and material for use by producers.
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 which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

"Duplicate Medicare supplement insurance" shall mean the sale or the attempt to knowingly sell to an individual a policy of insurance designed to supplement Medicare benefits as provided in The Health Insurance for the Aged Act, Title XVII 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 191 IAC 36.6(514D) which 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" shall mean 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 191 IAC 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" shall mean 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 may 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 shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

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

"Person" shall mean 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" shall also mean 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 chapter 514 and Iowa Code chapter 512A shall be deemed to be engaged in the business of insurance.

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

"Preneed funeral contract or prearrangement" shall mean 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" shall mean 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 shall mean any provision which 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" shall mean 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.

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 which 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 which 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 which 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 also contain the dollar amount of benefits payable or the period of time during which benefits are payable, or both, but may not refer to the cost of the policy.

g. An advertisement for a policy which 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 which 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 which utilizes a reduced initial premium rate in a manner which 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 all the provisions of 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." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. 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. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

c. An advertisement which 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 which 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 which 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 which 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 which 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 Illustrations Model Regulation, 191 IAC 14.

f. An advertisement or presentation which 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 which 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 which state or imply that their 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, Division II.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

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 which 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 IAC 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.

191—15.5(507B) Health insurance sales to individuals 65 years of age or older. The sale of duplicate Medicare supplement insurance is prohibited.

191—15.6(507B) Preneed funeral contracts or prearrangements.

15.6(1) *Advertising.* An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

a. The fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, and

b. The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

15.6(2) *Application.* Prior to accepting an application, initial premium or deposit, an insurer or producer must adequately disclose:

a. The relationship of the life insurance policy or annuity contract to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

b. The impact on the prearrangement of any:

(1) Changes in the life insurance policy or annuity contract including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds,

(2) Penalties to be incurred by the policyholder as a result of failure to make premium payments,

(3) Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

c. A list of the merchandise and services which are supplied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

d. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the prearrangement;

e. Any penalties or restrictions including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

f. The fact that a sales commission or other form of compensation is being paid and, if so, the identity of the person to whom it is paid.

191—15.7(507B) Twisting prohibited. No insurer or producer shall engage in the act of twisting.

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 which the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify its 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 which 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 which 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 which is a duplication of a policy or rider which 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 *"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 which involve nominal interim ownership immediately precedent to transfer of ownership into a trust are exempt from this subrule.

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.

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 which 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.

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 which are subject to the federal Employee Retirement Income Security Act of 1974 (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 which 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 which 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 which 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 which 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.
[**ARC 7796B**, IAB 5/20/09, effective 5/22/09; **ARC 7965B**, IAB 7/15/09, effective 8/19/09]

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 which 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 which 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 public health.

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, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix IV 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 which 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.

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, subsection 12;

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.

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.

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 which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

"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 2001 Iowa Acts, chapter 69, section 7.

"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, disability income insurance, or long-term care insurance.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.

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, subsection 9, as amended by 2001 Iowa Acts, chapter 69.

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 which 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.

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 which 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).

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 which 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 which 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 which deviates from the methods described in paragraph *"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 which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which 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.

15.43(10) Diminished value. Rescinded IAB 4/28/04, effective 4/7/04.

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.

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 which 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.

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 15.53(507B) that are issued on or after July 1, 2004.

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.

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

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.

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.

191—15.56 to **15.60** Reserved.

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

191—15.61(507B) Purpose. The purpose of these rules 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 which must be disclosed and the method for disclosing it 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. The rules in this division apply to all annuities not exempted under rule 15.62(507B) that are issued on or after July 1, 2004.

191—15.62(507B) Applicability and scope. These rules apply to all group and individual annuity contracts and certificates except:

15.62(1) Registered or nonregistered variable annuities or other registered products;

15.62(2) Immediate and deferred annuities that contain no nonguaranteed elements;

15.62(3) Annuities used to fund:

a. An employee pension plan which is covered by the Employee Retirement Income Security Act (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.

This subrule 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(4) Structured settlement annuities; and

15.62(5) Charitable gift annuities as defined in Iowa Code chapter 508F.

191—15.63(507B) Definitions. For purposes of these rules:

"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.

"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.

"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.

191—15.64(507B) Standards for delivery of disclosure document and Buyer's Guide.

15.64(1) Delivery requirement. When an insurer or an insurance producer receives an application for an annuity contract, the insurer or insurance producer shall provide the applicant the disclosure document described in rule 191—15.65(507B) and the Buyer's Guide to Fixed Deferred Annuities, hereafter "the Buyer's Guide," in the current form prescribed by the National Association of Insurance Commissioners or in language approved by the commissioner of insurance.

15.64(2) 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 with an insurance producer, the insurance producer shall provide the disclosure document and the Buyer's Guide at or before the time of application.

b. When an application for an annuity contract is taken by means other than a face-to-face meeting, the insurer shall send the applicant 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, the insurer may provide the Buyer's Guide and the disclosure document in the mailing which invites prospective applicants to apply for an annuity contract.

d. When an application is received via the Internet, the insurer may comply with this rule by taking reasonable steps to make the Buyer's Guide and disclosure document available for viewing and printing on the insurer's Web site.

15.64(3) A solicitation for an annuity contract which occurs other than in a face-to-face meeting shall include a statement that the proposed applicant may contact the Iowa insurance division for a free annuity 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 annuity Buyer's Guide.

15.64(4) 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 the state law or rule.

191—15.65(507B) Content of disclosure documents. 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. At a minimum, the following information shall be included in the disclosure document:

15.65(1) The generic name of the contract, the company product name, if different, and form number and the fact that it is an annuity;

15.65(2) The insurer's name and address;

15.65(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, including but not limited to:

a. The guaranteed, nonguaranteed and determinable elements of the contract, and the limitations of those elements, if any, and an explanation of how the elements and limitations operate;

b. An explanation of the initial crediting rate, 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;

c. Periodic income options both on a guaranteed and nonguaranteed basis;

d. Any value reductions caused by withdrawals from or surrender of the contract;

e. How values in the contract can be accessed;

f. The death benefit, if available, and how it will be calculated;

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

h. Impact of any rider, such as a long-term care rider;

15.65(4) Specific dollar amount or percentage charges and fees, listed with an explanation of how they apply; and

15.65(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

191—15.66(507B) Report to contract owners. For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, 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:

1. The beginning and ending date of the current report period;
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;
3. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and
4. The amount of outstanding loans, if any, as of the end of the current report period.

191—15.67(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 rule and its application to other persons or circumstances shall not be affected.

DIVISION V
SUITABILITY IN ANNUITY TRANSACTIONS

191—15.68(507B) Purpose. The purpose of these rules is to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the times of the transactions are appropriately addressed. The rules in this division apply to all annuities not exempted under rule 15.69(507B) that are issued on or after January 1, 2007.

191—15.69(507B) Applicability and scope.

15.69(1) These rules shall apply to any recommendation to purchase or exchange an annuity made to a consumer by an insurance producer, or by an insurer where no producer is involved, that results in the purchase or exchange recommended.

15.69(2) Unless otherwise specifically included, this rule shall not apply to recommendations involving:

a. Direct-response solicitations where there is no recommendation based on information collected from the consumer.

b. Contracts used to fund the following:

(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 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;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.

191—15.70(507B) Definitions. For purposes of this division:

"Annuity" means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.

"Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

"Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

191—15.71(507B) Duties of insurers and of insurance producers.

15.71(1) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs.

15.71(2) Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

a. The consumer's financial status;

b. The consumer's tax status;

c. The consumer's investment objectives; and

d. Such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the consumer.

15.71(3) An insurer or insurance producer's recommendation shall be reasonable under all the circumstances actually known to the insurer or insurance producer at the time of the recommendation. However, neither an insurance producer, nor an insurer where no producer is involved, shall have any obligation to a consumer under subrule 15.71(1) related to any recommendation if a consumer:

a. Refuses to provide relevant information requested by the insurer or insurance producer;

b. Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; or

c. Fails to provide complete or accurate information.

15.71(4) Establishment and maintenance of a system of supervision.

a. An insurer either shall assure that a system to supervise recommendations that is reasonably designed to achieve compliance with this rule is established and maintained by complying with 15.71(4)*"c"* to *"e"* or shall establish and maintain such a system including, but not limited to:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this rule.

b. A general agent and independent agency either shall adopt a system established by an insurer to supervise recommendations of its insurance producers that is reasonably designed to achieve compliance with this rule, or shall establish and maintain such a system including, but not limited to:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of records that are reasonably designed to assist in detecting and preventing violations of this rule.

c. An insurer may contract with a third party, including a general agent or independent agency, to establish and maintain a system of supervision as required by 15.71(4)*"a"* with respect to insurance producers under contract with or employed by the third party.

d. An insurer shall make reasonable inquiry to assure that the third party contracting under 15.71(4)*"c"* is performing the functions required under 15.71(4)*"a"* and shall take such action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following:

(1) Annually obtain a certification from a third party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions; and

(2) Based on reasonable selection criteria, periodically select third parties contracting under 15.71(4)*"c"* for a review to determine whether the third parties are performing the required functions. In conducting the review, the insurer shall perform those procedures that are reasonable under the circumstances.

e. An insurer that contracts with a third party pursuant to 15.71(4)*"c"* and that complies with the requirements to supervise in 15.71(4)*"d"* shall have fulfilled its responsibilities under 15.71(4)*"a."*

f. An insurer, general agent or independent agency is not required by 15.71(4)*"a"* or *"b"* to:

(1) Review, or provide for review of, all insurance producer solicited transactions; or

(2) Include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer, general agent or independent agency.

g. A general agent or independent agency contracting with an insurer pursuant to 15.71(4)*"c"* shall promptly, when requested by the insurer pursuant to 15.71(4)*"d,"* give a certification as described in 15.71(4)*"d"* or give a clear statement that the general agent or independent agency is unable to meet the certification criteria.

h. No person may provide a certification under 15.71(4)*"d"*(1) unless:

(1) The person is a senior manager with responsibility for the delegated functions; and

(2) The person has a reasonable basis for making the certification.

15.71(5) Compliance with the National Association of Securities Dealers Conduct Rules pertaining to suitability shall satisfy the requirements under this rule for the recommendation of variable annuities. However, nothing in this subrule shall limit the insurance commissioner's ability to enforce the provisions of this rule.

191—15.72(507B) Mitigation of responsibility.

15.72(1) The commissioner may order:

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of the rules of this division;

b. An insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division; and

c. A general agency or independent agency that employs or contracts with an insurance producer to sell or solicit the sale of annuities to consumers, to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division.

15.72(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.

191—15.73(507B) Record keeping.

15.73(1) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer 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 an insurance producer.

15.73(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.

191—15.74 to **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.

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 which sells indexed products in Iowa.

"Producer" means a person required to obtain an insurance license under Iowa Code chapter 522B.

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.

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 Web site, www.iid.state.ia.us.

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.

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).

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 Web site at www.iid.state.ia.us.

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.

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.

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 which can be applied toward payment of gross premiums which 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 which 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 which 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 which 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 which 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.

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 Public Health, and the Iowa Department of Public Health 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 calling the national AIDS hotline at 1-800-342-2437.

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 which 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 Public Health. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice which 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 _____, 19 _____

Witness _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

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 com plaint 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 Web site (if available)].

These rules are intended to implement Iowa Code chapters 507B and 522B.

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◊ 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.

CHAPTER 16
REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

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

DIVISION I

Rescinded IAB 8/7/02, effective 9/11/02

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.

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 Iowa Administrative Code 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 which 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 522.

"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 which is purchased.

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 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. As used in this subrule, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee.

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.

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. No approval shall be required when amendments to the notice are limited to the omission of references not applicable to the product being sold or replaced.

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.

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"* above;

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 *"e"* of subrule 16.25(1); 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 which 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 in paper, photographic, microprocessed, magnetic, mechanical or electronic media or by any process which accurately reproduces the actual document.

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. With regard to financed purchases, the credit may be limited to the amount that the face amount of the existing policy is reduced by the use of existing policy values to fund the new 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 to the applicant 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, which shall include:

(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.

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. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

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 it can demonstrate that it 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).

191—16.29(507B) Violations and penalties.

16.29(1) Any failure to comply with these rules shall be considered a violation of Iowa Administrative Code 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 Iowa Administrative Code 191—Chapter 15.

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.

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 A1—Rescinded IAB 6/14/00, effective 5/17/00.

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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CHAPTER 17
LIFE AND HEALTH REINSURANCE AGREEMENTS

191—17.1(508) Authority and purpose. This chapter is adopted and promulgated by the commissioner of insurance pursuant to Iowa Code section 505.8 and chapter 508.

The insurance division recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

However, it is improper for a licensed insurer, in the capacity of a ceding insurer, to enter into reinsurance agreements for the principal purpose of producing a significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival. The terms of such agreements referred to herein and described in rule 17.3(508) would violate:

1. Iowa Code section 508.11 relating to financial statements which do not properly reflect the financial condition of the ceding insurer;
2. Iowa Code section 521B.2 relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and
3. Iowa Code section 507C.12 relating to creating a situation that may be hazardous to policyholders and the people of this state.

191—17.2(508) Scope. This chapter shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar regulation in their domiciliary state. This chapter shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This chapter shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

191—17.3(508) Accounting requirements.

17.3(1) No insurer subject to this chapter shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the division if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured.

b. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

c. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of any amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

d. The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded.

e. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

f. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies, for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk categories:

(1) Morbidity.

(2) Mortality.

(3) Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(4) Credit quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

(5) Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or moneys received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(6) Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

+ — Significant; 0 — Insignificant

RISK CATEGORY

	a	b	c	d	e	f
Health Insurance - other than LTC/LTD*	+	0	+	0	0	0
Health Insurance - LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+

Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium (dump-in premiums allowed)	0	+	+	+	+	+

*LTC = Long Term Care Insurance
*LTD = Long Term Disability Insurance

g. (1) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in subparagraph (2) of this paragraph *"g"*) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(2) Notwithstanding the requirements of subparagraph (1) of this paragraph *"g,"* the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

1. Health Insurance—LTC/LTD
2. Traditional Non-Par Permanent
3. Traditional Par Permanent
4. Adjustable Premium Permanent
5. Indeterminate Premium Permanent
6. Universal Life Fixed Premium (no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\,(I + CG)}{X + Y - I - CG}$$

Where:	I	is the net investment income (Exhibit 2, Column 7)
	CG	is capital gains less capital losses (Exhibit 4, Column 6)
	X	is the current year cash and invested assets (Page 2, Column 1) plus investment income due and accrued (Page 2, Column 1) less borrowed money (Page 3, Column 1)
	Y	is the same as X but for the prior year

h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.

i. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

j. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

k. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

17.3(2) Notwithstanding 191—subrule 17.3(1), an insurer subject to this chapter may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner may deem consistent with the insurance code or rules, including actuarial interpretations or standards adopted by the insurance division.

17.3(3) *a.* Agreements entered into after the effective date of this chapter which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent

amendments thereto, shall be filed by the ceding company with the commissioner within 30 days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this rule and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this division. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this rule.

b. Any increase in surplus net of federal income tax resulting from arrangements described in paragraph *"a"* of this subrule shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance ceded" line, page 4 of the Annual Statement, as earnings emerge from the business reinsured.

*[For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus Account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

At the end of year N + 1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66% of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and - $1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus Account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.]

*NOTE: Brackets supplied by agency.

191—17.4(508) Written agreements.

17.4(1) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the division, unless the agreement, amendment, or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

17.4(2) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

17.4(3) The reinsurance agreement shall contain provisions which provide that:

a. The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

b. Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

191—17.5(508) Existing agreements. Insurers subject to this chapter shall, by December 31, 1994, reduce to zero any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this chapter which, under the provisions of this chapter, would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or rules in existence immediately preceding the effective date of this chapter.

These rules are intended to implement Iowa Code chapter 508.

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[Filed 8/13/93, Notice 7/7/93—published 9/1/93, effective 10/6/93]

CHAPTER 18
CEMETERIES

191—18.1(523I,566A) Perpetual care cemeteries.

18.1(1) Cemeteries commencing business after July 1, 1995. Cemeteries organized on or after July 1, 1995, or which commence business in this state on or after July 1, 1995, shall operate as a perpetual care cemetery and shall not sell or offer interment rights to the public without a perpetual care cemetery permit from the administrator.

18.1(2) Cemeteries commencing business before July 1, 1995. A cemetery organized before July 1, 1995, and commencing business before July 1, 1995, may operate as a nonperpetual care cemetery or as a perpetual care cemetery. A perpetual care cemetery shall not sell or offer interment rights to the public without a perpetual care cemetery permit from the administrator. To continue to operate as a perpetual care cemetery, the cemetery must establish a fund as an irrevocable trust to provide for the care and maintenance of the cemetery for which it was established and shall provide for the appointment of a trustee, with perpetual succession, and set aside and deposit in the perpetual care fund not less than the amount required by Iowa Code Supplement section 566A.3.

18.1(3) A minimum perpetual care and maintenance guarantee fund of $25,000 is required for any cemetery commencing business on or after July 1, 1995, which is not owned or operated by a religious organization or a political subdivision of the state.

18.1(4) A minimum perpetual care and maintenance guarantee fund of $25,000 is required for any cemetery commencing business on or after July 1, 1953, and before July 1, 1995, which is not owned or operated by a religious organization or a political subdivision of the state.

191—18.2(523I,566A) Administration.

18.2(1) Iowa Code Supplement chapters 523I and 566A shall be administered by the commissioner of insurance of the state of Iowa. As deputy administrator, the Iowa superintendent of securities shall be the principal operations officer responsible to the commissioner for the routine administration of the Acts and management of the administrative staff of the administrator.

18.2(2) In the absence of the commissioner, whether because of the vacancy in the office, by reason of absence, physical disability or other cause, the superintendent of securities shall be the acting administrator and shall, for the time being, have and exercise the authority conferred upon the commissioner. The commissioner may from time to time delegate to the superintendent of securities any or all of the functions assigned to the commissioner in Iowa Code Supplement chapters 523I and 566A.

18.2(3) The administrator shall employ officers, attorneys, accountants, investigators, and other employees as shall be needed for administration of Iowa Code Supplement chapters 523I and 566A.

18.2(4) Upon request, the commissioner may honor requests from interested persons for interpretative opinions.

191—18.3(523I,566A) Public access to hearings. Every hearing in an administrative proceeding shall be open to the public.

191—18.4 Reserved.

191—18.5(523I,566A) Forms—content. Copies of all necessary forms and instructions may be obtained from the Iowa Securities Bureau, Lucas State Office Building, Room 214, Des Moines, Iowa 50319. The list which follows describes the forms which members of the public shall use when dealing with the bureau, unless waived by the commissioner, and computer-generated information may be accepted. Each direction shall be complied with and each question shall be answered in the same manner as if the forms and instructions were embodied in these rules.

FORM NUMBER	DESCRIPTION
C-1	Annual Report by Nonperpetual Care Cemeteries. Used by cemeteries required to report under Iowa Code Supplement section 566A.2D.
C-2	Annual Report by Perpetual Care Cemeteries. Used by cemeteries required to report under Iowa Code Supplement section 566A.2E.
C-3	Perpetual Care Cemetery Permit Application. Used by applicants when filing for a perpetual care cemetery permit.
C-4	Perpetual Care Cemetery Permit.

191—18.6(523I,566A) Annual report by perpetual care cemeteries. The annual report filed pursuant to Iowa Code Supplement section 566A.2E shall include an audit fee of $3 for each deed issued during the period of the report, provided, however, that an audit fee shall not be required for the first ten deeds issued each year.

191—18.7(523I,566A) Annual reports and perpetual care cemetery permits. For purposes of assisting cemeteries in filing annual reports and permit applications, the administrator may generate computer-generated forms with information filled in, as contained in the administrator's records, to the extent possible. However, the cemetery must correct any incorrect information before filing the report or application with the administrator.

These rules are intended to implement Iowa Code Supplement chapters 523I and 566A.

[Filed 7/12/96, Notice 2/28/96—published 7/31/96, effective 9/4/96]

CHAPTER 19
PREARRANGED FUNERAL CONTRACTS
[Prior to 10/22/86, Insurance Department[510]]

Rescinded IAB 10/24/07, effective 9/28/07

PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE RATE AND FORM FILING PROCEDURES

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

DIVISION I
FORM AND RATE REQUIREMENTS

191—20.1(505,509,514A,515,515A,515F) General filing requirements.

20.1(1) Insurance companies 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). Insurance companies 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 Web site at www.serff.org.

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.

191—20.2(505) Objection to 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 10 days' written notice of the time and place of the hearing to the person or association filing the demand, 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.

191—20.3(515,515A,515C,518,518A,520) Letter of transmittal. Rescinded IAB 10/25/06, effective 11/29/06.

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) All endorsements, riders and agreements restricting coverage provisions of the policy form previously issued must provide a signature line for acceptance by the named insured.

20.4(3) A form filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from its receipt.

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 who are specifically excluded by Iowa Code section 515F.5 and residual market mechanisms.

a. Advisory organizations may file on behalf of their member and subscriber companies prospective loss costs, supplementary rate 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 to 515F.6 or 515F.23 to 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 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. The insurer's rates shall be the prospective loss costs filed by the advisory organization which have been put into effect in accordance with 20.5(1)*"a,"* combined with the loss cost adjustments which are filed in accordance with this paragraph.

c. An insurer may satisfy its obligation to make filings of supplementary rating information by becoming a participating insurer of a licensed advisory organization which makes such filings and by authorizing the commissioner to accept such filings on its behalf, subject to any modifications filed by the insurer.

d. 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.

20.5(3) Insurers making filings in their own behalf and advisory organizations shall identify each page filed by printing, typing or stamping their own name thereon.

20.5(4) If a company filing rates used the manuals of an advisory organization in its filings, any portion of the manuals of the organization which 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(5) For residual market mechanisms, insurers making filings in their own behalf shall identify the submission as an independent filing or a deviation from the bureau filing. A deviation filing is a submission which 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. If an insurer has previously filed forms modifying coverage provided by the applicable standard or bureau forms, such fact should be noted in the rate filing.

191—20.6(515A) Exemption from 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 proposed rate from the filing requirement.

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 with information filed with the commissioner by an advisory organization.

This rule is intended to implement Iowa Code section 515A.4(6).

191—20.7(515E) Risk retention and purchasing groups. Rescinded IAB 11/22/06, effective 12/27/06.

191—20.8(515A) Rate filings for crop-hail insurance. Rate filings for crop-hail insurance shall be submitted on or before March 15 of each calendar year. Each company may file one set of rates per policy plan per calendar year which 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 which justifies the filed rate.

191—20.9(515F) Licensing advisory organization. Rescinded IAB 3/28/07, effective 5/2/07.

191—20.10(515F) Exemptions. Rescinded IAB 3/28/07, effective 5/2/07.

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 515.109:

Aircraft hull and aviation liability
Difference-in-conditions
Kidnap-ransom
Manuscript policies and endorsements issued to not more than two insureds in Iowa
Political risk
Reinsurance
Terrorism
War risk
Weather insurance

20.11(2) Insurers shall be exempt from filing rates for the lines of insurance exempted in 20.11(1).

20.11(3) An insurer shall within 30 days of request provide the commissioner with any of the information which is exempted from form and rate filing requirements.

191—20.12(515,515F) Use of credit history in underwriting and making of rates for personal automobile and homeowners policies. Rescinded IAB 11/24/04, effective 12/29/04.

191—20.13 to **20.40** Reserved.

These rules are intended to implement Iowa Code chapter 515F and Iowa Code section 515.109.

DIVISION II
IOWA FAIR PLAN ACT

191—20.41(515,515F) Purpose. This division is intended to implement and interpret 2003 Iowa Acts, chapter 119, 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.

191—20.42(515,515F) Scope. This division shall apply to all insurers licensed to write property insurance in Iowa.

191—20.43(515,515F) Definitions.

"Basic property insurance" means insurance against direct loss to property as defined in the standard fire policy and extended coverage, vandalism, and malicious mischief endorsements; homeowners insurance; and such other coverage or classes of insurance as may be added to the FAIR Plan by the commissioner. Basic property insurance shall include:

1. Coverage provided in the customary fire policy and in the customary extended coverage and builders risk endorsements.
2. Coverage against loss or damage by burglary or theft, or both.
3. Coverage at least equivalent to that provided in a modified coverage form homeowners policy.

"Habitational risk" means:

1. Dwellings, permanent or seasonal, designed for occupancy by not more than four families or containing not more than four apartments.
2. Private outbuildings used in connection with any of the risks described in "1."
3. Trailer homes at a fixed location.
4. Household and personal property in risks described in "1" to "3."

5. Tenants' contents in dwellings or apartment houses.

"Iowa FAIR Plan" or *"the Plan"* means the nonprofit, unincorporated mandatory risk-sharing facility established by this division to provide for basic property insurance.

"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, 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 which 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 Plan, 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.

191—20.44(515,515F) Eligible risks.

20.44(1) 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.

20.44(2) The maximum limits of coverage for the type of basic property insurance for customary fire and extended coverage which may be placed under the Plan are those established by the governing committee from time to time.

20.44(3) The maximum limits of coverage for the type of basic property insurance for burglary and theft which may be placed under the Plan are those established by the governing committee from time to time.

20.44(4) The maximum limits of coverage for the type of basic property insurance for homeowners coverage which may be placed under the Plan are those established by the governing committee from time to time.

191—20.45(515,515F) Membership.

20.45(1) 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.

20.45(2) An insurer's membership terminates when the insurer is no longer authorized to write basic property insurance in Iowa, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(3) Any voluntary insurer member may terminate its membership only as of the last day of the fiscal year of the Plan by giving written notice to the Plan 30 days prior to the last day of the fiscal year of the Plan. The governing committee upon a majority vote may terminate the membership of a voluntary insurer. Any such terminated member shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(4) Subject to the approval of the commissioner, the governing committee may charge a reasonable annual membership fee.

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.

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 on 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, with the approval of the commissioner, a rate service organization as defined in Iowa Code chapter 515F, 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 manager shall annually prepare an operating budget which shall be subject to approval of the governing committee.

20.47(5) 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(6) 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(7) The governing committee shall authorize the manager to file rates, surcharge schedules and forms for prior approval by the commissioner.

20.47(8) The governing committee shall prepare such agreements and contracts as may be necessary for the execution of this division consistent with its provisions.

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.

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.

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.

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 it fails to meet reasonable underwriting standards as set forth in 20.52(515,515F). Reasonable underwriting standards as set forth in 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.

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. Characteristics of ownership or maintenance of building including any two of the following conditions:

(1) Failure to pay real estate taxes on a property after the taxes have been delinquent for one year or more. Real estate taxes shall not be deemed to be delinquent for this purpose even if they are due and constitute a lien so long as a grace period remains under local law during which such taxes may be paid without penalty.

(2) Failure, within the insured's control, to furnish water for 30 consecutive days or more.

(3) Failure, within the insured's control, to furnish heat for 30 consecutive days or more during the heating season.

(4) Failure, within the insured's control, to furnish public lighting for 30 consecutive days or more.

e. Physical condition of buildings which results in an outstanding order to vacate, in an outstanding demolition order or in being declared unsafe in accordance with the applicable law.

f. One or more of the conditions for nonrenewal as listed in 20.54(515,515F) currently exist. The Plan shall upon notice that conditions at the buildings have changed consider new application for coverage.

g. Vandalism and malicious mischief coverage shall not be provided for a dwelling or commercial property where the property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least $500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period.

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 which have been approved by the commissioner.

20.52(2) Reserved.

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 which 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 which 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 which 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.

20.53(4) Liability insurance may not be provided where there is a business operating at the insured location, unless the applicant has in force a business liability policy with limits of at least $100,000 per occurrence providing premises liability coverage.

20.53(5) Liability insurance shall not be provided where the applicant owns three or more horses or other riding animals, unless the applicant has in force a liability policy with limits of at least $100,000 per occurrence providing coverage for the ownership and use of the horses or other riding animals.

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 which 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 due to paragraphs *"l"* and *"m."*

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 which 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. The elapsed time under this paragraph is a length of time over 60 days where the damage remains unrepaired, unless there are known to be extenuating circumstances.

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. Property has been abandoned for 90 days or more.

h. Utilities such as electric, gas or water services have been disconnected or the insured has failed to pay an account for such services within 120 days.

i. Real estate taxes have not been paid for a two-year period after the taxes have become delinquent. Real estate taxes shall not be deemed to be delinquent for this purpose if they are due and constitute a lien so long as a grace period remains under local law under which taxes may be paid without penalty.

j. 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.

k. 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.

l. 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 which are the responsibility of the owner named insured or due to the actions of any person defined as an insured under the policy.

m. Theft frequency in which there have been more than two thefts, each loss amounting to at least $500, in a 12-month period.

n. Material misrepresentation in any statement to the Plan.

o. On homeowners policies, excessive theft or liability losses. If a given property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least $500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period, the Plan may convert the homeowners policy to a dwelling policy without vandalism and malicious mischief coverage.

20.54(2) The Plan shall terminate all insurance contracts in accordance with Iowa Code sections 515.80, 515.81A, and 515.81B.

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, it must be resubmitted with a new application and accompanied by a current rejection notice. The Plan shall reinspect the risk before coverage is provided.

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 which 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 $20 shall not be billed to an insurer, but will be accumulated as a deferred assessment until the cumulative amount deferred is at least $20.

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.

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 which 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.

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.

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 20.49(515,515F). Producers shall follow the rules and procedures of the Plan.

191—20.59(515,515F) Review by commissioner. The governing committee shall report to the commissioner the name of any insurer or producer which 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.

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.

These rules are intended to implement 2003 Iowa Acts, chapter 119.

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[1] See IAB Insurance Division

CHAPTER 21
REQUIREMENTS FOR EXCESS AND SURPLUS LINES, RISK RETENTION GROUPS AND PURCHASING GROUPS

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

191—21.1(515) Definitions. In addition to the definitions provided in Iowa Code chapters 515 and 515E, the following definitions shall apply to this chapter, unless the context clearly requires otherwise:

"Division" means the Iowa insurance division.

"Excess and surplus lines insurance" means surplus lines insurance.

"NAIC UCAA" means a National Association of Insurance Commissioners Uniform Certificate of Authority Application form.

"Nonadmitted insurer" means an insurer that is not licensed by or admitted to do business in this state.

"Place" means obtaining insurance for an insured with a specific insurer.

"Producer" means the person who places the policy with the insurance company. The producer may be either a resident or nonresident of this state and must be licensed in Iowa to sell insurance classified as excess and surplus lines.

"Qualified surplus lines carrier" means a nonadmitted insurer that the division has determined is qualified to provide surplus lines coverage as set forth in Iowa Code section 515.120, but in no event shall "qualified surplus lines carrier" include an insurer described in Iowa Code section 515.122.

"Surplus lines insurance" means insurance on a risk or a part of a risk for which there is no market available through the original insurance producer in Iowa; therefore, the risk needs to be placed with a qualified surplus lines carrier, in accordance with the provisions of Iowa Code chapter 515 and this chapter.

[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.2(515) Qualified surplus lines carriers' duties.

21.2(1) *Insurer liable.* Where, pursuant to Iowa Code section 515.120, coverage is placed with a qualified surplus lines carrier, the qualified surplus lines carrier shall be liable for the premium tax required by Iowa Code section 515.120.

21.2(2) *How premium tax quoted.* A qualified surplus lines carrier or a broker for a qualified surplus lines carrier is authorized to quote a premium which includes tax as is required by Iowa Code section 515.120, 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 which included a premium tax component when promulgated. Any fees collected from residents of this state are considered part of the premium and thus are subject to taxation.

[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.3(515) Producers' duties.

21.3(1) *Producer collection of tax.* A producer who places insurance in qualified surplus lines carriers shall collect premium tax from the qualified surplus lines carriers by withholding 1 percent of the premiums for such tax.

21.3(2) *Electronic reporting of premium tax.* A producer who places insurance with a qualified surplus lines carrier shall file electronically the premium tax information with the division 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 producer who has placed insurance with qualified surplus lines carriers when the policies have been issued during the preceding calendar year shall file electronically with the division or as otherwise directed by the division a sworn report of all such business written during the preceding calendar year and shall submit the amount to cover the taxes due on said business. If no business was written during the preceding calendar year, no report is required. Failure to file an annual return or pay the taxes imposed by Iowa Code section 515.120 et seq., will be deemed grounds for the revocation of a producer's license by the insurance division, and failure

to file an annual return or pay taxes within the time requirements of this rule will subject the producer to the penalties of Iowa Code section 515.121.
[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.4(515) Producers' duty to insured; evidence of coverage. A producer who places coverage with a qualified surplus lines carrier as defined herein shall 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 section 515.120, by a nonadmitted company in Iowa and as such is not covered by the Iowa Insurance Guaranty Association." A producer may comply with this rule by typing or stamping a verbatim copy of this language in a clear and conspicuous place on the policy.
[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.5(515) Procedures for qualification and renewal of a nonadmitted insurer as a qualified surplus lines carrier.

21.5(1) *Application and procedures for initial qualification of a nonadmitted insurer as a qualified surplus lines carrier.*

a. Any insurer who wishes to qualify under Iowa Code section 515.120 as a nonadmitted insurer shall make an application.

b. The application shall contain the following information, which also is listed on the division's Web site, www.iid.state.ia.us:

(1) A completed NAIC UCAA Expansion Application, available through the division's Web site, www.iid.state.ia.us, or through the NAIC Web site, www.naic.org/industry.

(2) A designation of a licensed Iowa resident producer qualified to write excess and surplus lines insurance.

(3) Remittance of the greater of a $100 filing fee or a retaliatory fee, and a $500 examination fee for all new applicants.

c. In addition to the above requirements, the insurer shall:

(1) Maintain the greater of either minimum capital and surplus of $5 million or risk-based capital pursuant to Iowa Code chapter 521E, and

(2) Have been actively in operation for at least three years without significant changes in ownership or management during the three-year period.

These financial and management requirements may be waived by the division upon a finding that the insurer will be offering coverage in a line of insurance for which there is an unavailability of capacity and an extraordinary need for coverage in this state. The division may require other information as deemed necessary.

21.5(2) *Procedures for renewal of a nonadmitted insurer as a qualified surplus lines carrier.* A nonadmitted insurer that is not an alien insurer as defined in Iowa Code section 515.70 and that met the division's requirements for becoming a qualified surplus lines carrier shall, by March 1 of each year following the year of qualification:

a. Continue to comply with paragraph 21.5(1)*"c"*;

b. Pay a $100 renewal fee; and

c. Submit to the division the documents and materials listed on the division's Web site, www.iid.state.ia.us.

21.5(3) *Failure to comply.* Failure of a nonadmitted insurer to timely submit the materials required in this rule or to otherwise fail to comply with this rule shall result in the termination of the nonadmitted insurer's status as a qualified surplus lines carrier.
[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.6(515E) Risk retention groups. A risk retention group as defined in Iowa Code chapter 515E may utilize its producers to report and pay premium taxes or may pay the taxes directly. If producers are utilized, they shall follow the procedure set forth in subrule 21.3(2). In the event that the group desires to

pay the premium tax directly, the group shall file electronically with the division through the division's Web site, www.iid.state.ia.us.
[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

191—21.7(515E) Procedures for qualification as a risk retention group.

21.7(1) Any insurer who wishes to register under Iowa Code chapter 515E as a risk retention group shall file with the division an application that contains:

a. The information set forth in Iowa Code sections 515E.4(1) and (2), which also is listed on the division's Web site, www.iid.state.ia.us; and

b. Remittance of a $100 filing fee plus any additional retaliatory fees.

21.7(2) A risk retention group shall pay a $100 renewal fee by March 1 of each year following the year of registration. The risk retention group shall annually provide information requested by the division for determination of continued registration.

191—21.8(515E) Procedures for qualification as a purchasing group.

21.8(1) Prior to doing business in this state, a purchasing group shall furnish to the division notice that shall include:

a. The information set forth in Iowa Code section 515E.8, which also is listed on the division's Web site, www.iid.state.ia.us; and

b. Remittance of a $100 filing fee.

21.8(2) A registered purchasing group shall 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.

191—21.9(515,515E) Failure to comply; penalties. Failure of a producer, insurer, risk retention group or purchasing group to comply with this chapter or with Iowa Code section 515.120, 515.121, or 515.122, or chapter 515E may subject the producer, insurer, risk retention group or purchasing group to penalties set forth in Iowa Code chapter 507B or Iowa Code section 515.121.
[**ARC 7663B**, IAB 3/25/09, effective 4/29/09]

These rules are intended to implement Iowa Code sections 515.120 to 515.122.

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CHAPTER 22
FINANCIAL GUARANTY INSURANCE

191—22.1(515C) Definitions.

22.1(1) *"Financial guaranty insurance"* means a surety bond, insurance policy or, when issued by an insurer, an indemnity contract and any guaranty similar to a surety bond, insurance policy, or insurer-issued indemnity contract, under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee, or indemnitee as a result of any of the following events:

a. Failure of an obligor on a debt instrument or other monetary obligation (including common or preferred stock guarantied under a surety bond, insurance policy, or indemnity contract) to pay when due principal, interest, premium, dividend, or purchase price of or on the debt instrument or monetary obligation, when the failure is the result of a financial default or insolvency, regardless of whether the obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted.

b. A change in the level of interest rates, whether short- or long-term, or the differential in interest rates between various markets or products.

c. A change in the rate of exchange of currency.

d. Inconvertibility of one currency into another for any reason, or inability to withdraw funds held in a foreign country resulting from restrictions imposed by a governmental authority.

e. A change in the value of a specific asset or commodity, financial or commodity index, or price levels in general.

f. Another event which the commissioner determines is substantially similar to any of those in paragraphs *"a"* through *"e."*

22.1(2) *"Financial guaranty insurance"* does not include:

a. Insurance of a loss resulting from an event described in subrule 22.1(1), if the loss is payable only upon the occurrence of any of the following, as specified in a surety bond, insurance policy, or indemnity contract:

(1) A fortuitous physical event.

(2) A failure of or deficiency in the operation of equipment.

(3) An inability to extract or recover a natural resource.

b. An individual or schedule public official bond.

c. A contract bond, including bid, payment, or maintenance bond, or a performance bond if the bond is guarantying the execution of any contract other than a contract of indebtedness or other monetary obligation.

d. A court bond required in connection with judicial, probate, bankruptcy, or equity proceedings, including a waiver, probate, open estate, and life tenant bond.

e. A bond running to the federal, state, county, or municipal government, or other political subdivision, as a condition precedent to granting of a license to engage in a particular business or of a permit to exercise a particular privilege.

f. A loss security bond or utility payment indemnity bond running to a governmental unit, railroad, or charitable organization.

g. A lease, purchase and sale, or concessionaire surety bond.

h. Credit unemployment insurance, meaning insurance on a debtor in connection with a specific loan or other credit transaction, to provide payments to a creditor in the event of unemployment of a debtor, for the installments or other periodic payments becoming due while a debtor is unemployed.

i. Credit insurance, meaning insurance indemnifying manufacturers, merchants, or educational institutions extending credit against loss or damage resulting from nonpayment of debts owed to them for goods or services provided in the normal course of their business.

j. Guarantied investment contracts issued by life insurance companies which provide that the life insurer itself will make specified payments in exchange for specific premiums or contributions.

k. Residual value insurance.

l. Mortgage guaranty insurance authorized by Iowa Code chapter 515C.

m. An indemnity contract or similar guaranty in which an insurer guaranties its obligations or indebtedness or the obligations or indebtedness of a subsidiary of which it owns more than 50 percent, other than a financial guaranty insurance corporation.

n. Any other form of insurance covering risks which the commissioner determines to be substantially similar to any of the forms in this subrule.

22.1(3) *"Industrial development bond"* means a security or other instrument under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a private industrial, commercial, or manufacturing purpose and not payable or guarantied by a governmental unit.

22.1(4) *"Investment grade"* means having a rating of not less than Baa3 by Moody's Investors Service or BBB- by Standard and Poor's Corporation, or a comparable rating by any nationally recognized rating service, or a rating of not less than 2 by the National Association of Insurance Commissioners, or, if not rated, having characteristics substantially comparable to obligations rated.

22.1(5) *"Municipal obligation bond"* means a security, or other instrument, including a state lease but not a lease of any other governmental entity, under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a substantial public purpose, and which is one or more of the following:

a. Payable from tax revenues, but not tax allocations, within the jurisdiction of the governmental unit.

b. Payable or guarantied by the United States or any agency, department, or instrumentality of the United States, or by a state housing agency.

c. Payable from rates or charges, but not tolls, levied or collected in respect of a nonnuclear utility project, public transportation facility other than an airport facility, or public higher education facility.

d. With respect to a lease obligation, payable from future appropriations.

22.1(6) *"Special revenue bond"* means a security, or other instrument under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a substantial purpose and not payable from the sources enumerated in subrule 22.1(5) in connection with the payment of a municipal obligation bond.

22.1(7) *"Security"* or *"secured"* means any or all of the following:

a. A deposit equal to at least the full amount of the principal of the insured obligation.

b. Collateral at least equal to the full amount of the principal of the insured obligation, or the scheduled cash flow from which is equal to or greater than the scheduled debt service on the insured obligation and is due prior to the date when the scheduled debt service is payable.

c. Property, provided the corporation has possession of evidence of the right, title or authority to claim or foreclose on the property or otherwise dispose of such property for value, the scheduled cash flow from which, or market value of which, is at least equal to the scheduled debt service on the insured obligation and is due prior to the date when the scheduled debt service is payable.

191—22.2(515) Financial requirements and reserves. An insurance company otherwise authorized under Iowa Code chapter 515 to write financial guaranty insurance shall do so only when all of the following requirements are satisfied:

22.2(1) It has paid-in capital of at least $1 million and surplus of at least $1 million.

22.2(2) It establishes a contingency reserve, net of reinsurance, as follows:

a. The contributions to the reserve shall be calculated by applying the following percentages to the net principal written each calendar year of guaranties issued or delivered in this state of:

1. Municipal obligation bonds, 0.8 percent.
2. Special revenue bonds, 1.2 percent.
3. Industrial development bonds, 1.6 percent.
4. Secured investment grade obligations, 1.6 percent.
5. Investment grade obligations not secured, 2.5 percent.
6. All other obligations guarantied, 3.0 percent.

b. (1) Quarterly additions to the reserve for paragraph *"a,"* "1," "2," and "3" above must be equal to the greater of one-eightieth of the amounts derived by applying the appropriate contribution

specified in paragraph *"a"* or 50 percent of the quarterly earned premiums on the guaranties and must be maintained for a period of 20 years.

(2) Quarterly additions to the reserve for paragraph *"a,"* "4" to "6" must be equal to the greater of one-fortieth of the amounts derived by applying the appropriate contribution specified in paragraph *"a"* or 50 percent of the quarterly earned premiums on the guaranties and must be maintained for a period of ten years.

c. The reserve may be released after the expiration of the applicable time period, listed in paragraph *"b,"* subparagraphs (1) and (2), in the same manner, except that a part of the reserve may be released proportional to the reduction in net total liabilities resulting from reinsurance and the reinsurer shall, on the effective date of the reinsurance, establish a reserve in an amount equal to the amount released.

d. A withdrawal from the contingency reserve, to the extent of any excess, may be made from the earliest contributions to the reserve remaining in the reserve:

(1) With the approval of the commissioner, in any year in which the actual incurred losses exceed 35 percent of earned premiums.

(2) Upon 30 days' prior notice to the commissioner, provided that the contingency reserve has been in existence for 40 quarters, for reserves subject to paragraph *"b,"* subparagraph (1), and 20 quarters, for reserves subject to paragraph *"b,"* subparagraph (2), upon demonstration that the amount carried is excessive in relation to the corporation's outstanding obligations.

22.2(3) In addition to the contingency reserve, the case basis method or other method as the commissioner may require must be used to determine loss reserve on guaranties issued or delivered in this state. This method shall include a reserve for claims reported and unpaid net of collateral. A deduction from loss reserves must be allowed for the time value of money by application of a discount rate equal to the average rate of return on the admitted assets of the insurer as of the date of the computation of the reserve. The discount rate shall be adjusted at the end of each calendar year.

22.2(4) The insurance company shall maintain an unearned premium reserve on guaranties issued or delivered in this state, net of reinsurance, computed on the month pro rata basis, if financial guaranty premiums are paid on an installment basis. All other financial guaranty premiums paid must be earned proportionately with the expiration of exposure, or by any other method the commissioner requires or approves.

These rules are intended to implement Iowa Code sections 511.8(5) and 515C.6.

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CHAPTER 23
MOTOR VEHICLE SERVICE CONTRACTS

191—23.1(516E) Purpose. This chapter is promulgated to implement and administer the provisions of Iowa Code chapter 516E, hereinafter referred to as the Act, which regulates the sale of motor vehicle service contracts.

191—23.2(516E) Applicability and scope. This chapter shall apply to all providers of motor vehicle service contracts issued, sold, or offered for sale in this state, such as automobile dealers who offer and sell motor vehicle service contracts and any third party administrators. This chapter also applies to all motor vehicle service contract reimbursement insurance policies issued by an insurer authorized to do business in this state.

191—23.3(516E) Application of insurance laws. The sale of a motor vehicle service contract shall not be deemed to include the sale of insurance. Thus, unless the provider is otherwise engaged in the sale of insurance, the provisions of the insurance laws of this state shall not be applicable to that provider. However, this rule shall not be construed to exempt any other warranties or service contracts other than motor vehicle service contracts, as defined in the Act, from the provisions of the insurance laws of this state.

191—23.4(516E) Administration.

23.4(1) The deputy administrator appointed under Iowa Code section 502.601 shall administer the Act. The superintendent of securities shall be the principal operations officer responsible to the commissioner for the routine administration of the Act and management of the administrative staff of the securities bureau.

23.4(2) In the absence of the commissioner, whether because of vacancy in the office, by reason of absence, physical disability, or other cause, the superintendent of securities shall be the acting administrator and shall, for the time being, have and exercise the authority conferred upon the commissioner. The commissioner may from time to time delegate to the superintendent of securities any or all of the functions assigned to the commissioner in the Act.

23.4(3) The superintendent of securities shall employ officers, attorneys, accountants, auditors, investigators, and other employees as shall be needed for the administration of the Act.

23.4(4) Upon request the commissioner may honor requests from interested persons for interpretative opinions.

191—23.5(516E) Public access to hearings. Every hearing in an administrative proceeding shall be open to the public unless by prior agreement all parties request that it be private.

191—23.6(516E) Public access to records.

23.6(1) The administrator shall keep a register of all filings and orders which have been entered. The register shall be open for public inspection.

23.6(2) Upon request and for a reasonable fee, the administrator shall furnish to any person copies of any register entry or any document which is a matter of public record and not confidential. Copies shall be available during normal business hours and may be certified upon request. In any administrative, civil, or criminal proceedings, a certified copy is prima facie evidence of the contents of the document certified.

23.6(3) Pursuant to Iowa Code chapter 22, the administrator and the attorney general may keep confidential information obtained during an investigation or audit.

191—23.7(516E) Filing procedures.

23.7(1) *Prepaid envelope.* The administrator may date-stamp and return material upon request if the filing is accompanied by a self-addressed envelope large enough to return the date-stamped material and with sufficient prepaid postage.

23.7(2) *Annual filing—late filing fee.* If the annual filing required by Iowa Code section 516E.3 is not filed or postmarked by the first day of August, the filing fee shall be accompanied by a late fee of $25. If the annual filing is not filed or postmarked by the first day of September, the filing shall be accompanied by a late fee of $50.

191—23.8(516E) Fees. The following fees are established by the commissioner:

1. Annual filing fee	$100.00
2. Certification	$ 5.00
3. Filing fee (filed or postmarked after August 1)	$125.00
4. Filing fee (filed or postmarked after September 1)	$150.00
5. Filing fee (filed or postmarked after August 1 and sales occurred)	$325.00
6. Filing fee (filed or postmarked after September 1 and sales occurred)	$350.00
7. Name change	$ 10.00
8. Record copies (per page)	$ 0.50
9. Printout of providers	$ 10.00
10. Printout of insurance companies	$ 10.00

All fees are nonrefundable.

191—23.9(516E) Forms. Copies of all required forms and instructions may be obtained from the Securities Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066. The public shall use Form MV-1, Notice of Annual Filing, when dealing with the bureau, unless this requirement is waived by the administrator. Computer-generated information may be accepted upon request. Incomplete forms will not be processed and will be returned to the sender.

191—23.10(516E) Prohibited acts—unfair discrimination or trade practices. A motor vehicle service contract provider shall not cause or permit any unfair discrimination between individuals of the same class in the rates charged for any contract, in the benefits received thereunder, in any of the terms or conditions of such contract, or in any other manner.

191—23.11(516E) Prohibited acts—unfair or deceptive trade practices involving used or rebuilt parts.

23.11(1) *Used parts.* Unless the parts were rebuilt in accordance with 23.11(2), a motor vehicle service contract provider may not use used parts to repair a motor vehicle covered by a motor vehicle service contract without prior written authorization by the vehicle owner.

23.11(2) *Rebuilt parts.* A motor vehicle service contract provider may not use rebuilt parts to repair a motor vehicle covered by a motor vehicle service contract unless:

a. The parts have been dismantled and reconstructed as necessary;

b. All of the internal and external parts have been cleaned and made free from rust and corrosion;

c. All impaired, defective, or substantially worn parts have been restored to a sound condition or replaced with new, rebuilt, or unimpaired used parts;

d. All missing parts have been replaced with new, rebuilt, or unimpaired used parts;

e. All necessary operations such as rewinding or machining have been performed; and

f. The parts have been put in working condition, using, if publicly available, the manufacturer's performance specifications in existence when the parts were originally manufactured as minimum standards.

191—23.12(516E) Violations. Any violation of these rules shall be considered a violation of Iowa Code chapter 516E and shall be subject to the provisions of Iowa Code sections 516E.6, 516E.13, and 516E.15.

191—23.13(516E) Procedures for public complaints.

23.13(1) Any member of the public or any federal, state, or local official may make and file a complaint with the administrator. The administrator shall process each complaint made against any provider which alleges certain acts or practices which may constitute one or more violations of the Act

or this chapter. Complaints received from sources outside the state of Iowa shall be processed in the same manner as those originating in Iowa.

23.13(2) Complaints may be mailed or delivered to the following address: Regulated Industries Unit, Securities Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066.

23.13(3) All complaints shall be made in writing and shall fully identify the complainant by name and address. If required by the administrator, complaints shall be made on forms prescribed and provided by the administrator.

23.13(4) Oral or telephone communications may not be considered or processed as complaints. However, any member of the administrator's staff may make and file a complaint based upon information and belief in reliance upon oral, telephone, or written communications received by the administrator.

These rules are intended to implement Iowa Code chapter 516E.

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CHAPTER 24
IOWA RETIREMENT FACILITIES

191—24.1(523D) Purpose. The following chapter is promulgated for the purpose of administering the provisions of Iowa Code chapter 523D, the Iowa retirement facilities Act, relating to senior adult congregate living facilities and continuing care retirement communities.

191—24.2(523D) Title. The Act may be cited as the "Iowa retirement facilities Act."

191—24.3(523D) Definitions. As used in the Act and this chapter, unless the context otherwise requires:

"Act" means Iowa Code chapter 523D, the Iowa retirement facilities Act.

"Actuarial forecast" means an analysis which is performed by a qualified actuary or an individual who has demonstrated to the satisfaction of the insurance division the necessary experience and educational background. Such analysis shall be in accordance with generally accepted actuarial principles and practices (GAAP) and shall include a statement of actuarial opinion, an actuarial balance sheet, a cash flow projection, and a statement of applicable actuarial methodology, formulas, and assumptions.

"Certified financial statements" means financial statements audited and certified by an independent certified public accountant in accordance with generally accepted auditing standards.

"Certified public accountant" means a person who has received from the Iowa accounting examining board a certificate as a certified public accountant who is in good standing and who is currently registered under Iowa Code section 542C.20 or holding certified public accountant certificates issued under the laws of another state.

"Commissioner" means the commissioner of insurance for the state of Iowa.

"Financial institution" means a state or federally insured bank, savings bank, savings and loan association, credit union, trust department thereof, or a trust company authorized to do business in the state of Iowa.

"Person" means an individual, corporation, trust, partnership or association, or any other legal entity.

"Qualified actuary" means an individual who is a member of the American Academy of Actuaries.

"Statement of financial feasibility" means a financial forecast, as defined by the American Institute of Certified Public Accountants (AICPA), of the revenues, expenses, working capital needs, and other financial requirements for the new or expanded facility or an alternative financial study in a form acceptable to the insurance division. The forecast period should include the development or expansion period and extend for five fiscal years from the date of initial occupancy. Unless waived by the commissioner, the statement of financial feasibility shall include a cash flow forecast with underlying assumptions and be presented in accordance with AICPA guidelines. The financial analysis shall be prepared by either a qualified actuary, a certified public accountant, or an individual who has demonstrated to the satisfaction of the insurance division the necessary experience and educational background.

"Statement of the market feasibility" means an analysis of the market conditions which (1) identifies and evaluates the potential market, including a demographic and economic profile of the population in the facility's market area; (2) identifies the existing or proposed facilities or similar businesses offering similar services in the potential market area, including, if available, the occupancy rate for existing facilities for the last three years; and (3) identifies the name and address of the person who prepared the feasibility study and the experience of the person in preparing similar studies or otherwise consulting in the field of continuing care or related health care fields.

191—24.4(523D) Administration.

24.4(1) The Act shall be administered by the regulated industries unit of the division of insurance. Although the Iowa commissioner of insurance shall be the administrator, the Iowa superintendent of securities, as deputy administrator, shall be the principal operations officer responsible to the

commissioner for the routine administration of the Act and management of the administrative staff of the Iowa securities bureau.

24.4(2) In the absence of the commissioner, whether because of vacancy in the office, by reason of absence, physical disability, or other cause, the superintendent of securities shall be the acting administrator and shall, during the absence, have and exercise the authority conferred upon the commissioner. The commissioner may from time to time delegate to the superintendent of securities any or all of the functions assigned to the commissioner by the Act.

24.4(3) Upon request the commissioner may honor requests from providers or potential providers for interpretative opinions indicating the commissioner's enforcement position on a proposed course of action detailed in the request for the interpretative opinion.

24.4(4) Upon request the commissioner may certify that photocopies provided by the division of insurance are full, true, and correct copies of the original instrument filed, kept or recorded by the division of insurance. The fee for the certification process is $5 per request.

191—24.5(523D) Misrepresentations.

24.5(1) A facility or provider shall not represent or imply in any manner that the facility or provider has been sponsored, recommended, or approved or that the facility's or provider's abilities or qualifications have in any respect been passed upon by the Iowa division of insurance or the state of Iowa.

24.5(2) Nonetheless, if the statements are factually correct, a facility or provider may state that a disclosure statement has been filed with the Iowa division of insurance in accordance with the Iowa retirement facilities Act. Likewise, if the statements are factually correct, a facility or provider may state (*a*) that the facility or provider has filed notice of new construction with the Iowa division of insurance in accordance with the Iowa retirement facilities Act or (*b*) that the commissioner of insurance has approved the release of escrowed funds.

191—24.6(523D) Complaints.

24.6(1) The division of insurance may receive and process each complaint made against any facility or provider which alleges certain acts or practices which may constitute one or more violations of the provisions of the Act. Where appropriate, complaints may be referred, in whole or in part, to other agencies. Any member of the public or the industry, or any federal, state, or local officials, may make and file a complaint with the commissioner. Complaints may be received from sources outside the state of Iowa and processed in the same manner as those originating in Iowa.

24.6(2) Before the division takes any action on a complaint, the facility or provider will be provided with a summary of information set forth in the complaint and an opportunity to provide a response to the allegations. If required by the division of insurance, complaints shall be made in writing on forms prescribed and provided by that division.

191—24.7(523D) Address for filings. All complaints, inquiries, correspondence, applications, and other filings under the Iowa retirement facilities Act or this chapter shall be addressed as follows: Regulated Industries Unit, Iowa Insurance Division, Lucas State Office Building, Second Floor, Des Moines, Iowa 50319.

191—24.8(523D) Fees. The following fees are hereby established by the division of insurance:

1. Initial filing fee	$100.00
2. Annual filing fee	$100.00
3. Certification	$ 5.00
4. Name change	$ 10.00
5. New construction filing fee	$250.00
6. Photocopies of records (per page)	$ 0.50
7. Printout of facilities	$ 10.00

All fees are nonrefundable.

191—24.9(523D) Forms. The forms listed in this rule are published by the Iowa insurance division, and copies of the forms may be obtained from the Regulated Industries Unit, Iowa Insurance Division, Lucas State Office Building, Second Floor, Des Moines, Iowa 50319. The division adopts and incorporates herein by reference the forms listed in this rule; and their use is required, where applicable, for compliance with the provisions of the Iowa retirement facilities Act and this chapter.

FORM NUMBER	DESCRIPTION
RFA-1	Notice of Annual Filing. Used by continuing care retirement communities and senior adult congregate living facilities to make their annual filing under the Act.
RFA-2	Notice of New Construction. Used by continuing care retirement communities and senior adult congregate living facilities to notify the insurance division of their intent to begin new construction.
RFA-3	Release of Escrowed Funds. Used by escrow agents or facilities to request the insurance division's approval for the release of escrowed funds.

191—24.10(523D) Financial statements, studies, and forecasts.

24.10(1) Financial statements shall be prepared in accordance with generally accepted accounting principles and practices (GAAP).

24.10(2) The financial statements shall be presented in a format that allows financial analysis of the contracting party undertaking to provide the continuing care. The contracting party may consist of an individual facility or numerous operating units. In some cases, where the financial condition and financial obligations of affiliated legal entities are relevant to the financial condition of the contracting party, preparation on a consolidated basis may be necessary. The financial statements shall provide sufficient financial disclosure to the continuing care resident to enable the resident to make an informed decision.

24.10(3) Studies or forecasts must disclose the basic assumptions used.

24.10(4) The following audited financial statements must be filed with the annual disclosure statement:

a. An income statement or a statement of revenues and expenses;

b. A statement of changes in equity or change in fund balances;

c. A balance sheet; and

d. A statement of cash flows.

191—24.11(523D) Amendments to the disclosure statement.

24.11(1) Amendments to the most recent disclosure statement may be filed with the division of insurance at any time. No filing fee is required.

24.11(2) The filing shall be clearly marked to show changes from the most recent disclosure statement filed with the division or the filing shall be accompanied by a cover letter briefly outlining each of the sections of the disclosure statement that has been amended.

24.11(3) The filing shall consist of either (*a*) two copies of the disclosure statement containing the revisions as it is distributed to a prospective resident (one copy marked to show changes) or (*b*) if the changes are made by an amendment or addendum, two copies of the revised pages.

24.11(4) Changes in the operations of a provider or facility which shall require an amendment to a disclosure statement include, but are not necessarily limited to, the following:

a. New or additional mortgages, security interests, loan commitments, long-term financing arrangements, or leases, which transaction materially affects the real property of the facility unless the material terms of such transaction were specifically described as a proposed transaction in the disclosure statement.

b. The sale of the facility to a new provider.

c. Changes in the provider's tax status.

d. A material change in the form of the resident contract.

191—24.12(523D) Standards for the disclosure statement.

24.12(1) *Readability.* Documents given to residents, prospective residents, and personal representatives, including disclosure statements and residents' contracts, shall be drafted in accordance with the following standards:

a. The language used shall be readable by a person of average intelligence and education.

b. All information presented should be conveyed in a logical sequence and in a clear and direct fashion.

c. Complex and compound sentences should be avoided.

d. Words should convey their commonly understood meanings.

e. Definitions shall be included for words or terms which cannot properly be explained or qualified in the text.

f. Frequent section headings should be used to permit ease in locating provisions.

g. Documents shall be printed in easily legible typeface in a size easily legible to the audience to whom the literature is directed. Upright type at least as large as 10-point type should be used.

24.12(2) *Form.* Documents shall be typed or printed on paper 8½ by 11 inches. The disclosure statement shall be bound or otherwise securely fastened.

24.12(3) *Cover page.* The cover page of the disclosure statement shall state, in a prominent location and in bold-faced type, "Disclosure Statement," the date of the disclosure statement, and a statement that the delivery of the disclosure to a contracting party before the execution of a contract for the provision of supportive services or continuing care is required by the Iowa retirement facilities Act, but that the disclosure statement has not been approved by any government agency or representative. If reference is made to a filing with the insurance division, the disclosure shall state that the division's review does not ensure accuracy or completeness of the information set out.

24.12(4) *Table of contents.* Multipaged documents shall contain a table of contents giving a comprehensive listing of all section headings used in the document. If the table of contents does not appear at the beginning of the document, the location of the table of contents shall be noted on the first page.

24.12(5) *Acknowledgment.* The last page of the disclosure statement shall consist of a detachable "acknowledgment of receipt" which shall be signed and dated by the resident. A copy of the acknowledgment shall be kept on file in the office of the provider for at least one year from the date of the acknowledgment.

24.12(6) *Advertising.* The disclosure statement shall contain no sales or advertising materials. Sales or advertising materials may be attached to the disclosure statement or packaged with the disclosure statement if the manner of attachment or packaging does not obfuscate the cover page of the disclosure statement.

These rules are intended to implement Iowa Code chapter 523D.

[Filed 3/10/93, Notice 10/14/92—published 3/31/93, effective 6/30/93]

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 2007 Iowa Acts, House File 499, section 7.

25.1(4) This chapter shall apply to acts or practices committed on or after January 1, 2008.

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 an active duty service member of the United States armed forces.

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. Individual stand-alone health policies, including disability income policies;

e. Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 et seq.;

f. Life insurance contracts offered through or by a nonprofit military association, qualifying under Section 501(c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

g. 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;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements of or assumptions of liabilities associated with personal injury litigation or of any dispute or claim resolution process; or

(6) Prearranged funeral contracts.

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.

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 (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 a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

"Insurer" means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

"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 which 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 which are subject to standard nonforfeiture law for life insurance; or
3. A premium deposit fund which:

- Contains only premiums paid in advance which 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.

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 a 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 which 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.

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 which 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 which 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 which 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 which 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 which 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 Healthcare 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 which 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) Which 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 which 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.

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 25.8(505).

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).

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 which can be given effect without the invalid provisions or application. To this end, all provisions of these rules are declared to be severable.

These rules are intended to implement Iowa Code chapter 505 and 2007 Iowa Acts, House File 499, section 7.

[Filed 10/5/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]

CHAPTER 26
Reserved

CHAPTER 27
PREFERRED PROVIDER ARRANGEMENTS

191—27.1(514F) Purpose. The purpose of this chapter is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred arrangements and the health benefit plans associated with those arrangements.

191—27.2(514F) Definitions. As used in this chapter, unless the context otherwise requires:

"Commissioner" means the commissioner of insurance.

"Covered person" means a person on whose behalf the health care insurer is obligated to pay for or provide health care services.

"Covered services" means health care services which the health care insurer is obligated to pay for or provide under the health benefit plan.

"Emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

"Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

"Health care insurer" means a third-party payer of health benefits including, but not limited to, a person providing a policy or contract providing for third-party payment or prepayment of health or medical expenses, including the following:

1. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
2. An individual or group hospital or medical service contract issued pursuant to Iowa Code chapter 509, 514 or 514A.
3. An individual or group health maintenance organization contract regulated under Iowa Code chapter 514B.
4. An individual or group Medicare supplement policy.
5. A fraternal benefit society.

"Health care provider" or *"provider"* means a provider of health care services as defined in rule 191—34.2(514).

"Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

"Preferred provider" means a health care provider or group of providers who have contracted to provide specified covered services.

"Preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this chapter.

191—27.3(514F) Preferred provider arrangements. Notwithstanding any provisions of law to the contrary, any health care insurer may enter into a preferred provider arrangement.

27.3(1) A preferred provider arrangement shall at minimum:

a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

b. Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may include among others:

(1) The review or control of utilization of health care costs.

(2) A procedure for determining whether health care services rendered are medically necessary.

c. Ensure reasonable access to covered services available under the preferred provider arrangement.

27.3(2) A preferred provider arrangement shall not unfairly deny health benefits for medically necessary covered services.

27.3(3) If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. An employer which contracts with health care providers for the exclusive benefit of that employer's employees and employees' dependents is exempt from this requirement. This exemption does not apply to any producer, agent, or administrator acting on behalf of one or more employers.

27.3(4) Rescinded IAB 7/14/99, effective 7/1/99.

191—27.4(514F) Health benefit plans.

27.4(1) A health care insurer may issue a health benefit plan which provides for incentives for covered persons to use the health care services of a preferred provider. The policies or subscriber agreements shall contain at least all of the following provisions:

a. A provision that if a covered person receives emergency services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, emergency services rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider, subject to any restriction which may govern payment by a preferred provider for emergency services.

b. A provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of nonpreferred providers.

27.4(2) If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

191—27.5(514F) Preferred provider participation requirements.

27.5(1) A health care insurer may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there is no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status.

27.5(2) Notwithstanding any other provision of this chapter, a health care insurer may issue policies or subscriber agreements which provide benefits for health care services only if the services have been rendered by a preferred provider, provided the program has met all standards imposed by the commissioner for availability and adequacy of covered services.

27.5(3) A health care insurer shall file with the commissioner for the commissioner's prior review a prototype of any preferred provider arrangement and of the health care plan's policy, contract, or subscriber agreement associated with the arrangement, together with any changes in the prototype. Use of the prototypical preferred provider arrangement and health care plan's policy, contract, or subscriber agreement is conditioned upon approval of these documents by the commissioner.

191—27.6(514F) General requirements. A health care insurer subject to this chapter shall be subject to and is required to comply with all other applicable laws and rules and regulations of this state.

191—27.7(514F) Civil penalties. Civil penalties for violation of this chapter shall be imposed in the amount, and pursuant to the procedure, set forth in Iowa Code sections 507B.6, 507B.7, and 507B.8.

191—27.8(514F) Health care insurer requirements.

27.8(1) A health care insurer shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health care insurer's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health care insurer or a person contracting with the health care insurer.

27.8(2) A health care insurer shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer that, in the opinion of the provider, jeopardizes patient health or welfare.

These rules are intended to implement Iowa Code section 514F.3 and 1999 Iowa Acts, Senate File 276.

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CHAPTER 28
CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

191—28.1(509) Purpose. The purpose of this chapter is to protect the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit accident and health insurance. Compliance with any disclosure requirements in this chapter shall not be deemed to be in compliance with the requirements set out in the Iowa consumer credit code and supporting rules. This chapter shall not be applicable to coverage provided by creditors at their own expense where no charge is made to the insured debtors for their coverage or to coverage which is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of a creditor.

191—28.2(509) Definitions.

"Consumer credit transaction" shall have the same definition as set out in Iowa Code section 537.1301(11) to (14).

"Credit accident and health insurance" means insurance on a debtor or debtors to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

"Credit insurance" means both credit life and credit accident and health insurance.

"Credit life insurance" means insurance on the lives of debtors pursuant to or in connection with a specific loan or other credit transaction.

"Creditor" means the lender of money or vendor or lessor of goods, services or property, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any lender, vendor, or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them.

"Credit transaction" means any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased, is to be made at a future date or dates.

"Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

"Indebtedness" means total amount repayable including principal, interest and finance charges.

"Lender-agent" means a creditor, as defined herein, who offers credit insurance or arranges for the offering of credit insurance to debtors.

"Open-end credit" means credit extended by a creditor under an agreement in which:

1. The creditor reasonably contemplates repeated transactions;
2. The creditor imposes a finance charge from time to time on an outstanding unpaid balance; and
3. The amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

"Person" means any natural person, partnership, corporation or other business entity.

191—28.3(509) Rights and treatment of debtors.

28.3(1) *Multiple plans of insurance.* If a creditor has available to the debtors more than one plan of credit life insurance or more than one plan of credit accident and health insurance, the debtors must be informed of all plans applicable to the credit transaction. All relevant plans shall be fully disclosed to the consumer prior to the preparation of any insurance documents and before the consumer becomes obligated on the credit transaction.

28.3(2) *Substitution.* When a creditor requires credit life insurance, credit accident and health insurance, or both, as additional security for an indebtedness, the debtor shall be given the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or by procuring and furnishing the required coverage through any insurer authorized to

transact insurance business in this state. If this subrule is applicable, the debtor shall be informed by the creditor of the right to provide alternative coverage before the transaction is completed.

28.3(3) *Evidence of coverage.*

a. All credit insurance shall be evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor at the time the indebtedness is incurred, except as provided in the following. If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered to the debtor at the time the indebtedness is incurred. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor.

b. Each individual policy or group certificate of credit insurance delivered or issued for delivery in this state shall, in addition to the other requirements of law, set forth:

(1) The name and home office address of the insurer and, on group certificates, an identification of the master policy;

(2) The identity of the insured debtor by name or any other reasonable alternative method of identification approved by the insurance commissioner;

(3) The amount of premium or identifiable insurance charge to the debtor, separately for the credit life insurance and credit accident and health insurance;

(4) A description of the coverage including the amount and term thereof;

(5) Any exceptions, limitations and restrictions;

(6) A statement that the benefits will be paid to the creditor to reduce or extinguish the indebtedness, and any excess shall be paid to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

c. A policy, certificate of credit insurance or notice of proposed insurance shall not contain provisions which would encourage misrepresentation or which are unjust, unfair, inequitable, misleading, deceptive or contrary to law or to the public policy of this state.

d. A credit life insurance or credit accident and health insurance policy violates paragraph *"c"* if it provides an amount of insurance less than the amount necessary to discharge the indebtedness, when it does not set forth clearly the information on the insured debtor's policy or certificate in not less than 10-point bold-faced type or in some other prominent method approved by the commissioner.

e. A notice of proposed insurance or a copy of the application for the policy, when delivered pursuant to paragraph *"a"* as evidence of coverage, violates paragraph *"c"* above, if it does not set forth the name and home office of the insurer; the name or names of the debtor; the premium or amount of payment by the debtor, separately for credit life or credit accident and health insurance; the amount, term and a brief description of the coverage provided. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage and shall be separate and apart from the loan, sale or other credit statement of account, instrument, or agreement, unless the information required by this subrule is prominently disclosed.

f. If an insurer other than the insurer named on the application, notice of proposed insurance, policy or certificate of insurance accepts the risk, the debtor shall receive a new policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged and, if the amount of the new premium is less, an appropriate refund shall be made.

g. If an insured debtor states that the debtor is under the maximum age for insurance, but is not, the insurer shall return the premium when this is discovered and no benefit will be paid.

h. If the insurer accepts premiums where the debtor has correctly stated the debtor's age, insurance coverage shall be effective regardless of age limitations or age exclusions unless a premium refund is made within 30 days following the date the application or notice of proposed insurance is received by the insurer.

i. No statements made by a debtor shall be used by an insurer as a basis for denying a claim unless the statement is contained in a written application for insurance signed by the debtor, a copy of which is

or has been furnished to the debtor or to the debtor's beneficiary, and the form of which has been filed with and approved by the insurance commissioner for use in connection with the policy form in question.

j. An application must identify the insurer providing the coverage. An application signed by the debtor is required whenever the policy contains an exclusion on account of age or other eligibility requirement.

28.3(4) *Claims processing.* All claims shall be promptly reported to the insurer or its designated claim representatives, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract, but in no event shall claims be settled more than 30 days after notification of the claim and compliance by the debtor of all requirements under the policy. All claims shall be paid or credited to the claimant pursuant to the policy provisions, or upon direction of the claimant to one specified. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designed as claim representative for the insurer in adjusting claims. However, a group policyholder may, by arrangement with the group insurer, pay or credit the claims due to the group policyholder subject to audit and review by the insurer.

28.3(5) *Termination of group credit insurance policy.*

a. If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under the policy shall be continued for the entire period for which the single premium has been paid.

b. If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, then the policy shall provide that, in the event of its termination for whatever reason, the termination notice shall be given to the insured debtor at least 30 days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The notice required in this paragraph shall be given by the insurer or, at the option of the insurer, by the creditor.

28.3(6) *Interest on premiums.* If the creditor adds identifiable insurance charges or premiums for credit insurance to the indebtedness and any direct or indirect finance carrying, credit or service charge is made to the debtor on the insurance charges or premiums, the creditor must remit and the insurer shall collect the premium within 60 days after it is added to the indebtedness.

28.3(7) *Renewal or refinancing of the indebtedness.* If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited to the debtor as provided in rule 28.8(509). In any renewal or refinancing of the indebtedness, the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least to the extent of the amount and term of the indebtedness outstanding at the time of renewal and refinancing of the debt. This subrule shall apply to all consumer credit transactions renewed pursuant to Iowa Code section 537.2504 or 537.2505.

28.3(8) *Maximum aggregate provisions.* A provision in a policy or certificate that sets a maximum limit on total payments must apply only to that policy or certificate.

28.3(9) *Voluntary prepayment of indebtedness.* If a debtor prepays the indebtedness other than as a result of death or through a lump sum disability payment:

a. Any credit life insurance covering the indebtedness shall be terminated and an appropriate refund of the credit life insurance premium shall be paid to the debtor in accordance with rule 28.9(509); and

b. Any credit accident and health insurance covering the indebtedness shall be terminated and an appropriate refund of the credit accident and health insurance premium shall be paid to the debtor in accordance with rule 28.9(509). If a claim under the coverage is in progress at the time of prepayment, the amount of refund may be determined as if the prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit accident and health

benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period.

28.3(10) *Involuntary prepayment of indebtedness.* If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate:

a. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit accident and health insurance premium in accordance with rule 28.9(509);

b. In the case of prepayment by a lump sum disability claim, an appropriate refund of the credit life insurance premium in accordance with rule 28.9(509);

c. In either case, the amount of the benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges.

28.3(11) *Amounts to be insured.*

a. Credit life insurance benefits shall be consistent with the premium charge. Credit life insurance may provide benefits in amounts which do not exceed, but may be less than, the scheduled amount of indebtedness, including unearned interest or finance charges, or the actual amount of unpaid indebtedness, whichever is greater.

b. Credit accident and health insurance may provide benefits not exceeding the amount of outstanding indebtedness inclusive of unearned interest or finance charges.

191—28.4(509) Policy forms and related material.

28.4(1) *Permissible forms.* Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

a. Individual policies of life insurance issued to debtors on the term plan;

b. Individual policies of accident and health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

c. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

d. Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

28.4(2) *Filing requirements.* All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, disclosure forms and riders delivered or issued for delivery in this state must be filed and approved by the insurance commissioner prior to use of the form.

28.4(3) *Issuance of policies.* All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business herein. No person shall, directly or indirectly, act within this state as agent in receiving or procuring applications for credit insurance for any company until procuring from the insurance commissioner a license to act as agent for that company.

191—28.5(509) Determination of reasonableness of benefits in relation to premium charge.

28.5(1) *General standard.* Under the credit insurance law, benefits provided by credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may be reasonably expected to develop a loss ratio of not less than 50 percent. With the exception of deviations approved under rule 28.11(509), the rates shown in rules 28.7(509) and 28.8(509), as adjusted pursuant to rule 28.10(509), shall be conclusively presumed to satisfy this general standard.

28.5(2) *Nonstandard coverage.* If any insurer files for approval of any form providing coverage more restrictive than that described in rules 28.7(509) and 28.8(509), the insurer shall demonstrate to the satisfaction of the insurance commissioner that the premium rates to be charged for the restricted

coverage will develop or may be reasonably expected to develop a loss ratio not less than that contemplated for standard coverage at the premium rates described in these rules.

28.5(3) *Coverage without separate charge.* If no specific charge is made to the debtor for credit insurance, the standards of this rule are not required to be used; but any premium rates resulting from the standards used which exceed the premium rate standards set out in rules 28.7(509) and 28.8(509) must be filed with the insurance commissioner. For purposes of this subrule, it will be considered that the debtor is charged a specific amount for insurance if an identifiable charge for insurance is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, or if there is a differential in finance, interest, service or other similar charge made to debtors who are in like circumstances, except for their insured or noninsured status.

191—28.6 Reserved.

191—28.7(509) Credit life insurance rates.

28.7(1) Premium rate. Credit life insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall be as set forth in paragraphs *"a"* and *"b"* below. Paragraph *"c"* below refers to premium rates for other types of benefits either alone or in combination with the type of benefits applicable to paragraphs *"a"* and *"b."*

a. $.89 per month per $1,000 of outstanding principal balance if premiums are payable on a monthly outstanding balance basis.

b. Gross coverage — decreasing term. If premiums are payable on a single premium basis and the amount of insurance decreases in equal monthly amounts, the prima facie premium rate shall be $.58 per annum per $100 of initial insured indebtedness.

c. Gross coverage — level term. If premiums are payable on a single premium basis when the benefit provided is level term, the prima facie rate shall be $1.07 per annum per $100 of initial insured indebtedness.

d. Joint coverage on either of the bases in paragraph *"a," "b,"* or *"c"* of this subrule shall be 166 percent of the specific rate for that type of coverage.

e. A combination of the appropriate rate for level term and the appropriate rate for decreasing term (with equal decrements), if coverage provided is a combination of level term and decreasing term (with equal decrements).

f. If the benefits provided are other than those described in the introduction to this subrule, premium rates for the benefits shall be actuarially consistent with the rates provided in paragraphs *"a," "b," "c,"* and *"d"* above.

28.7(2) The premium rates in 28.7(1) shall apply to policies providing credit life insurance to be issued with or without evidence of insurability, to be offered to all debtors, and containing:

a. No exclusions other than suicide within six months of the incurred indebtedness; and

b. Either no age restrictions or age restrictions making ineligible for coverage debtors 65 or over at the time the indebtedness is incurred or debtors having attained age 66 or over on the maturity date of the indebtedness.

c. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age 65.

d. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, no provision excluding or denying a claim for death resulting from a preexisting condition except for those conditions for which the insured debtor received medical diagnosis or treatment within six months preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within six months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the

advance or charge is posted to the plan account. Other more restrictive provisions may be used subject to appropriate rate adjustment approved by the insurance commissioner.

191—28.8(509) Credit accident and health insurance.

28.8(1) Premium rate. Credit accident and health insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall be as set forth in paragraphs *"a"* and *"b"* below. Paragraphs *"c," "d"* and *"e"* refer to premium rates for other types of benefits either alone or in combination with the type of benefits applicable to paragraphs *"a"* and *"b."*

a. If premiums are payable on a single premium basis for the duration of the coverage, the rates shall be as follows:

Single Premium Per $100 of Initial Insured Indebtedness

Months	Nonretroactive 14-Day Elimination	30-Day Elimination	Retroactive 14-Day Elimination	30-Day Elimination
12	$1.26	$0.72	$1.98	$1.53
24	$1.98	$1.44	$2.70	$2.25
36	$2.70	$2.16	$3.42	$2.97
48	$3.15	$2.61	$3.87	$3.42
60	$3.51	$2.97	$4.23	$3.78

Credit accident and health insurance rates for durations less than 12 months shall be derived by multiplying the number of months by one-twelfth of the 12-month rate. Rates for durations of more than 12 months but less than 60 months, which are not listed above shall be derived by straight-line interpolation between the listed rates, with the results rounded to the nearest cent. Rates for durations exceeding 60 months shall be derived by adding 3 cents to the 60-month rate for each month in excess of 60 months and rounding to the nearest cent.

b. If premiums are paid on the basis of a premium rate per month per $1,000 of outstanding insured indebtedness, these premiums shall be computed according to the following formula or according to a formula approved by the insurance commissioner which produces rates actuarially equivalent to the single premium rates:

$$Op_n = \frac{20\ SP_n}{n+1}$$

Where SP_n=Single Premium Rate per $100 of initial insured indebtedness repayable in n equal monthly installments.

Op=Monthly Outstanding Balance Premium Rate per $1,000.

n=Original repayment period, in months.

c. The actuarial equivalent of paragraphs *"a"* and *"b"* shall be used if the coverage provided is a constant maximum indemnity for a given period of time.

d. An appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month, if the coverage provided is a combination of a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month.

e. If the benefits provided are other than those described in paragraph *"a"* above, rates shall be actuarially consistent with rates provided in paragraphs *"a," "b," "c"* and *"d."*

f. The outstanding balance rate for credit accident and health insurance may be either a term-specified rate or may be a single composite term outstanding balance rate applicable to all loans made under open-end or closed-end credit plans.

28.8(2) The premium rates in 28.8(1) shall apply to all policies providing credit accident and health insurance, be issued with or without evidence of insurability, be offered to all eligible debtors, and contain:

a. No provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six months preceding the effective date of the debtor's coverage and which caused loss within the six months following the effective date of coverage. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, the effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the advance or charge is posted to the plan account.

b. No other provision which excludes or restricts liability in the event of disability caused in a specific manner except that it may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries.

c. No actively-at-work requirement more restrictive than one requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage. "Full-time" means a regular work week of not less than 30 hours. A debtor shall be deemed to be actively at work if absent from work due solely to regular day off, holiday or paid vacation.

d. No age restrictions, or only age restrictions making ineligible for coverage debtors 65 or over at the time the indebtedness is incurred or debtors who will have attained age 66 or over on the maturity date of the indebtedness.

e. A daily benefit equal in amount to one-thirtieth of the monthly benefit payable under the policy for the indebtedness.

f. A definition of "disability" which provides that during the first 12 months of disability the insured shall be unable to perform the duties of the occupation at the time the disability occurred, and thereafter the duties of any occupation for which the insured is reasonably fitted by education, training or experience. This paragraph shall not apply to lump-sum disability coverage.

g. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age 66.

191—28.9(509) Refund formulas.

28.9(1) Refund formulas must be filed with and approved by the insurance commissioner prior to use.

28.9(2) In the event of termination, no charge for credit insurance may be made for the first 15 days of a loan month and a full month may be charged for 16 days or more of a loan month.

28.9(3) The requirement that refund formulas be filed with the insurance commissioner shall be considered fulfilled if the refund formulas are set forth in the individual policy or group certificate filed with the insurance commissioner.

28.9(4) No refund of $1 or less need be made.

191—28.10(509) Experience reports and adjustment of prima facie rates.

28.10(1) Each insurer doing insurance business in this state shall annually file with the insurance commissioner and the NAIC Support and Services Office a report of credit life and credit accident and health business written on a calendar-year basis. The report shall utilize the Credit Insurance Supplement-Annual Statement Blank as approved by the National Association of Insurance Commissioners. The filing shall be made in accordance with and no later than the due date in the instructions to the annual statement and should be sent separately to the life and health bureau.

28.10(2) The insurance commissioner will, no later than on a triennial basis, review the loss ratio standards set forth in rule 28.5(509), and the prima facie rates set forth in rules 28.7(509) and 28.8(509) and determine the rate of expected claims on a statewide basis, compare the rate of expected claims with the rate of actual claims for the preceding triennium determined from the incurred claims and earned

premiums at prima facie rates reported in the annual statement supplement, and publish the adjusted actual statewide prima facie rates to be used by insurers during the next triennium. These rates will reflect the difference between *(a)* actual claims based on experience; and *(b)* expected claims based on the loss ratio standards set forth in rule 28.5(509) applied to the prima facie rates set forth in rules 28.7(509) and 28.8(509).

28.10(3) The actual prima facie rates adjusted pursuant to subrule 28.10(2) above shall be published by bulletin from the insurance commissioner to all credit life and credit accident and health insurers licensed in Iowa.

191—28.11(509) Use of rates—direct business only.

28.11(1) *As used in this rule:*

"Earned premiums" means gross written premiums minus refunds on terminations, with this result adjusted for the change in unearned premium reserve.

"Experience" means "earned premiums" and "incurred claims" during the experience period.

"Experience period" means the most recent period of time for which experience is reported, but not for a period longer than three full years.

"Incurred claims" means total claims paid during the experience period, adjusted for the change in claim reserve.

28.11(2) *Use of prima facie rates.* An insurer that files rates or has rates on file that are not in excess of the prima facie rates shown in rules 28.7(509) and 28.8(509), to the extent adjusted pursuant to rule 28.10(509), may use those rates without further proof of their reasonableness.

28.11(3) *Use of rates higher than prima facie rates.* An insurer may file for approval of and use rates that are higher than the prima facie rates shown in rules 28.7(509) and 28.8(509), to the extent adjusted pursuant to rule 28.10(509), if it can be expected that the use of higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of the higher rates) that is not less than 50 percent for those accounts to which the higher rates apply and that the upward deviations will not result on a statewide basis in that insurer having a ratio of claims incurred to premiums earned less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to rule 28.10(509).

If rates higher than the prima facie rates shown in rules 28.7(509) and 28.8(509), to the extent adjusted pursuant to rule 28.10(509), are filed for approval, the filing shall specify the account to which the rates apply. The rates may be:

a. Applied uniformly to all accounts of the insurer; or

b. Applied on an equitable basis approved by the insurance commissioner to only one or more accounts of the insurer for which the experience has been less favorable than expected.

28.11(4) *Approval period of deviated rates.*

a. A deviated rate will be in effect for a period of time not longer than three years based on the most recent three-year experience period. An insurer may file for a new rate before the end of a rate period, but not more often than once during any 12-month period.

b. Notwithstanding the provision of 28.11(2), if an account changes insurers, the rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on the account, if sooner.

28.11(5) *Use of rates lower than filed rates.* An insurer may at any time use a rate for an account that is lower than its filed rate without notice to the insurance commissioner.

191—28.12(509) Supervision of credit insurance operations.

28.12(1) Each insurer transacting credit insurance in this state shall be responsible for conducting a thorough periodic review of creditors, with respect to their credit insurance business, to ensure compliance with the insurance laws of this state and the rules promulgated by the insurance commissioner. The review required above shall include, but not be limited to, a determination that:

a. The proper charges are being made by the creditor;

b. The proper refunds are being made;

c. All known claims are being filed and properly handled;

d. Amounts of insurance payable on death in excess of the amount necessary to discharge the indebtedness are properly refunded; and

e. The creditor is promptly and fairly processing complaints concerning its credit insurance operations and is maintaining proper procedures for and records of the complaints processed.

28.12(2) Written records of the reviews shall be maintained by the insurer for review by the insurance commissioner.

191—28.13(509) Prohibited transactions. The following practices, when engaged in by insurers in connection with the sale or placement of credit insurance, or as an inducement, shall constitute unfair methods of competition and shall be subject to the unfair trade practices Acts of this state.

28.13(1) The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than the payment of agent's commissions.

28.13(2) Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that the same shall affect or take the place of a deposit of money or securities which otherwise would be required of the creditor by the bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

28.13(3) Deposit by an insurer of money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank or financial institution to other depositors of like amounts. This subrule shall not be construed to prohibit the maintenance by an insurer of demand deposits or premium deposit accounts reasonably necessary for use in the ordinary course of the insurer's business.

28.13(4) Failure by the insurance companies to refund, within a reasonable time period, unearned premiums to the person who originally paid the premium.

28.13(5) Misrepresentation or deception by the lender-agent by either leading a borrower to believe that the borrower must purchase insurance from a specific insurance company or failing to inform the borrower that insurance is not mandatory and by including the cost of insurance premiums in all loan quotations.

28.13(6) Any representation, either express or implied, that could reasonably cause a borrower to believe that the loan might be jeopardized if insurance is not purchased through the recommended channels and, by taking advantage of the weak bargaining position of the debtor, cause the purchase of insurance which might not otherwise be wanted.

28.13(7) Claim adjusting not in reasonable conformity with policy provisions.

28.13(8) Failure by both companies and agents to inform the debtor of coverage.

28.13(9) Charging rates that are unfairly discriminatory in that the company charges different rates for identical groups with similar mortality, morbidity, expenses and other valid underwriting characteristics.

28.13(10) Any violation of Iowa Code chapter 507B or Iowa Code section 714.16.

191—28.14(509) Disclosure and readability.

28.14(1) *Disclosure.* When a premium or identifiable charge is payable by a debtor for credit insurance coverage offered by a creditor, at the time insurance is applied for, disclosures shall be made to the principal debtor and copies given and retained, in accordance with state and federal law. The creditor shall also disclose the optional nature of the coverage, premium or identifiable charge separately by type of coverage, eligibility requirements, and policy limitations and exclusions. These disclosures shall be made prominently above the space for the signature indicating election to obtain the coverage. These disclosures may be made in conjunction with either *(a)* the federal truth-in-lending disclosure, or *(b)* a notice of proposed insurance, or insurance policy or certificate.

28.14(2) *Readability.* The insurance commissioner shall not approve any form unless the policy or certificate is written in nontechnical, readily understandable language, using words of common everyday usage:

a. Each insurer is required to test the readability of its policies or certificates by use of the Flesch Readability Formula, as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974);

b. A total readability score of 40 or more on the Flesch scale is required;

c. All policies or certificates within the scope of this rule shall be filed with the insurance commissioner accompanied by a certification setting forth the Flesch score and certifying the compliance with the guidelines set forth in this rule.

191—28.15(509) Severability. If any provision or clause of this chapter or its application to any person or situation is held invalid, the invalidity shall not affect any other provision or application of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared severable.

191—28.16(509) Effective date.

28.16(1) This chapter shall take effect January 1, 1991.

28.16(2) Any deviations thought to be appropriate by an insurer as a result of promulgation of this chapter shall be filed in accordance with the provisions of rule 28.11(509) no later than January 1, 1991.

28.16(3) Certificates, notices of proposed insurance and premium rates in connection with existing group policies shall conform to the requirements of this chapter not later than the anniversary date of the group policy next following January 1, 1991.

191—28.17(509) Fifteen-day free examination. The certificate of insurance, notice of proposed insurance, or individual policy may be returned to the creditor within 15 days of receipt of the policy or certificate for a full refund of premium paid, if after examination, the debtor(s) is not satisfied with the insurance for any reason. Notice of the 15-day free examination right shall be prominently printed upon the cover of the insurance policy, certificate of insurance or notice of proposed insurance.

These rules are intended to implement Iowa Code chapter 509.

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CHAPTER 29
CONTINUATION RIGHTS UNDER GROUP ACCIDENT AND HEALTH INSURANCE POLICIES

191—29.1(509B) Definitions. As used in this chapter:

"COBRA" means Title X of the federal Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272), as amended by the Tax Reform Act of 1986 (P.L. 99-514).

"Continuation right" refers to the right under Iowa Code chapter 509B of an employee or member or the employee's or member's spouse and dependent children whose coverage under a group accident and health insurance policy would terminate because of termination of employment or membership or dissolution or annulment of marriage or death of the employee or member to continue their accident and sickness insurance under the policy for the period, and under the terms specified, in that chapter.

"Employer" means that person which provides group accident or health insurance to its employees, or former employees, or the dependents of such persons, regardless of whether the employer directly contracts with an insurance company for a policy or obtains insurance by virtue of its membership in an organization which is deemed to be a "group policyholder."

"Group policyholder" means a person which both contracts with an insurance company for accident or health insurance policies and provides group accident or health insurance to individuals by virtue of their membership in an organization. An organization shall not be deemed to be a "group policyholder" to the extent that its members are "employers" and those "employers" in turn provide benefits to their employees and their dependents under the "employer's" benefit plan. Hence, if an individual has group accident or health insurance by virtue of employment, all obligations fall on the "employer" even if that insurance is provided by virtue of the "employer's" membership in an organization which is deemed to be a "group policyholder."

"Policy" means the group accident and health insurance policy maintained by an employer or group policyholder for the employer's employees or group policyholder's members to implement the employer's or group policyholder's benefit plan for its employees or members.

191—29.2(509B) Notice regarding continuation rights.

29.2(1) An employer or group policyholder must provide written notice of the continuation right arising by virtue of termination of employment or membership, other than the notice required by Iowa Code section 509B.3(7), no later than ten days after termination.

29.2(2) The employee or member shall make an election regarding continuation of coverage in writing within ten days of the later of the date the insurance coverage would cease by virtue of termination of employment or membership or the date the notice set forth in subrule 29.2(1) is given and pay the premiums for the continuation coverage within 31 days of the date the group insurance would otherwise terminate. Payment by the employee or member shall be made in advance of coverage commencing.

29.2(3) An employer or group policyholder need only give written notice of termination of continuation coverage by reason of nonpayment of premium by the employee or member once, in advance, to the employee or member in some general form such as the certificate of coverage referred to in section 509B.3(7).

29.2(4) In the event of a right to continuation coverage arising because of dissolution or annulment of marriage or death of the employee or member, the person eligible for continuation, who shall be the spouse or the custodial parent or legal guardian on behalf of a dependent child, must notify the employer or group policyholder of the occurrence of the event within 30 days after the dissolution or annulment of marriage or death of the employee or member. Within ten days of receipt of that notice, the employer or group policyholder shall give the person notice of the continuation right, and that person shall have ten days from the date the latter notice is received to elect continuation coverage in writing from the employer or group policyholder.

29.2(5) An election to continue coverage received by an employer or group policyholder from an employee or member or other eligible person shall be promptly transmitted to the issuer of the policy.

The issuer shall then cause coverage to be effective within ten days of receipt by the employer or group policyholder of the election, subject to receipt of the premium from the employee or member.

29.2(6) Notwithstanding subrule 29.2(5), continuation coverage shall run from the date of the qualifying event. An adequate premium to cover this period may be charged by an insurer.

191—29.3(509B) Qualifying events for continuation rights.

29.3(1) A dependent child ceasing to be a dependent of its parent or legal guardian is not an event qualifying for a continuation right.

29.3(2) Loss of continuation rights under COBRA, chapter 509B, or any other state group health insurance continuation law, is not an event qualifying for a continuation right.

29.3(3) Multiple qualifying events shall not be recognized under chapter 509B.

29.3(4) Voluntary termination of membership in an association shall not be a qualifying event.

191—29.4(509B) Interplay between chapter 509B and COBRA.

29.4(1) In the event an employee is eligible for a continuation right under Iowa Code chapter 509B and is also eligible for continuation of benefits from the employer under COBRA, an employer shall be deemed to comply with the requirements of chapter 509B if the employer offers to qualified beneficiaries the continuation right under COBRA. An election in favor of COBRA continuation shall satisfy the requirements of chapter 509B.

29.4(2) In lieu of, and as an alternative to the procedure set forth in subrule 29.4(1), the employer may give the employee continuation benefits, and charge the employee for continuation costs, on terms most favorable to the employee, as between chapter 509B and COBRA. For example, an employee could offer continuation for the period provided in COBRA — 18 months, as opposed to the 9 months under chapter 509B — but only at the cost to the employee allowable under chapter 509B — 100 percent of the per-employee cost, as opposed to the 102 percent per-employee cost allowable under COBRA.

191—29.5(509B) Effective date for compliance.

29.5(1) An insurer renewing an existing policy on or after July 1, 1987, shall provide a continuation right in its policy no later than the renewal date of the policy.

29.5(2) Policies issued or delivered on or after July 1, 1987, shall contain the continuation right as of the date of issuance or delivery.

These rules are intended to implement Iowa Code sections 509B.3 and 509B.5.

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LIFE AND HEALTH INSURANCE

CHAPTER 30
LIFE INSURANCE POLICIES

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

191—30.1(508) Purpose. In the best interest of the citizens of Iowa and to maintain a fair and honest life insurance market, certain types of life policy forms and certain policy provisions shall be either prohibited, altered or clarified as set out herein.

191—30.2(508) Scope. These rules shall apply to all insurance policies issued by insurance companies holding a certificate of authority under the provisions of Iowa Code chapter 508.

191—30.3(508) Definitions. Certain life insurance policy forms and provisions referred to herein shall have the following meaning:

30.3(1) *Founders policy.* The term or name assigned to a policy of insurance offered to the public by a newly organized stock life insurance company, issued on a participating basis with the representations that the purchasers will share preferentially in the future divisible surplus earnings of the company arising from all classes of business, both participating and nonparticipating, and all plans of insurance.

30.3(2) *Profit-sharing policy.* It is any policy form which contains provisions or is represented in such a way that the policyholder will be eligible to preferentially participate in any future distribution of general corporate profits.

30.3(3) *Coupon policy.* It is any policy or contract of life insurance, other than annuity, which contains in addition to basic life insurance benefits a series of annual pure endowment benefits evidenced in the policy contract by a series of coupons each of which matures on the maturation date of an annual pure endowment. For the purposes of these rules, policies containing annual pure endowments evidenced by coupons, passbooks or other devices generally acquainted with savings, banking or investment institutions shall be considered coupon policies.

30.3(4) *Pure endowment benefit.* It is a guaranteed insurance benefit, actuarially determined, the payment of which is contingent upon the survival of the insured to a specific point in time.

191—30.4(508) Prohibitions, regulations and disclosure requirements. In accordance with the purpose expressed in 30.1(508) and in conjunction with the intent of Iowa Code section 508.28, the use of certain types of policy forms and policy provisions shall be subject to the following prohibitions and regulations:

30.4(1) *Policy names.* Any insurance policy labeled or described as a founders, charter or coupon policy or names of similar connotation shall not be approved for use in this state on or after the effective date of these rules, and furthermore no policies so named or labeled heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(2) *Founders policy.* No founders policy as herein defined shall be approved for use in this state on or after the effective date of these rules, and furthermore no founders policy as herein defined heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(3) *Profit-sharing policy.* No profit-sharing policy shall be approved for use in this state on or after the effective date of these rules, and furthermore no profit-sharing policy heretofore approved shall be issued or delivered in this state on or after March 1, 1964. This subrule does not intend to restrict or prohibit the sale in this state of any participating life insurance policy where the dividend or abatement of premium is derived solely from the profits of that class of participating business.

30.4(4) *Coupon policy.* No coupon policy shall be approved or issued in this state after the effective date of these rules, and furthermore no coupon policy heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(5) *Guaranteed pure endowment benefits.* No policy containing a series of guaranteed pure endowment benefits shall be approved for use after the effective date of these rules unless it meets the following requirements:

a. The gross premium charged for this benefit shall be separately stated in a size and style of type equal in prominence to that stating the gross premium for the other benefits contained in the policy.

b. The payment of any guaranteed pure endowment benefit shall not be made contingent upon the payment of premiums falling due on or after the time the pure endowment benefit has matured.

c. The amount of the guaranteed series of pure endowment benefits shall be expressed in dollar amounts and shall not be presented or defined, either in the policy or any sales and advertising material, as a "percentage" of any of the premiums or benefits contained therein.

d. No participating policy shall include as part of its benefits a guaranteed pure endowment benefit.

e. The language and terminology of the policy or any of the sales and advertising materials used in connection with any policy, which has a series of pure endowment benefits therein, shall not purport to represent the pure endowment benefit of the policy to be anything other than a guaranteed insurance benefit for which a premium is being paid by the policyholder.

191—30.5(508) General filing requirements.

30.5(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings pursuant to rule 191—20.1(505,509,514A,515,515A,515F).

30.5(2) Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing, unless the 60-day period is waived by the division for good cause. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

30.5(3) A filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from its receipt by the division.

30.5(4) Any insured or established organization with one or more insureds among its members may object to a form or rate filing pursuant to rule 191—20.2(505).

191—30.6(508) Back dating of life policies. Upon the specific written request of an applicant for life insurance, an insurer may issue a policy with an effective date not more than six months prior to the date of the policy application. This regulation shall not be construed to prohibit the exercise of any exchange or conversion privileges in any policy or contract.

191—30.7(508,515) Expiration date of policy vs. charter expiration date. The mere fact that a corporate contract may extend beyond the term of the life of the corporation does not destroy it. We believe as a matter of public policy, insurance corporations frequently enter into such contracts. This is graphically illustrated in the case of a life insurance contract issued by a company with a limited corporate period. It has been held that the renewal of articles of incorporation is a continuation of the original corporate period which lends support to the proposition that it is within the public interest that contracts of this nature be permitted.

191—30.8(509) Electronic delivery of group life insurance certificates.

30.8(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of group life insurance certificates in an efficient manner by insurers and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 509.2(7), and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

30.8(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 and 515.

30.8(3) *Electronic delivery—insurance companies.* The insurer will be deemed to comply with the requirements of Iowa Code section 509.2(7) if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The insurer takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which can be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the insurer furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

30.8(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 509.2(7) if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

These rules are intended to implement Iowa Code sections 505.8, 508.25, 508.28 and 508A.4 and chapter 509.

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[1] See IAB Insurance Division

CHAPTER 31
LIFE INSURANCE COMPANIES—VARIABLE ANNUITIES CONTRACTS

[Appeared as Ch 3, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

191—31.1(508) Definitions. When used in this regulation:

"Commissioner" shall mean the insurance commissioner of Iowa.

"Contracts on a variable basis" or *"Variable contract"* shall mean any (group or individual) policy or contract issued by an insurance company which provides for insurance or annuity benefits which may vary according to the investment experience of any separate or segregated account or accounts maintained by the insurer as to such policy or contract, as provided for in Iowa Code sections 508.31 and 508.32.

191—31.2(508) Insurance company qualifications.

31.2(1) No company shall deliver or issue for delivery variable contracts within this state unless it is licensed under Iowa Code chapter 508 entitled "Life Insurance Companies," to do a life insurance or annuity business in this state; and the commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. To this end the commissioner shall consider among other things:

a. The history and financial condition of the company,

b. The character, responsibility and fitness of the officers and directors of the company, and

c. The law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

31.2(2) If the company is licensed and is a subsidiary of an admitted life insurance company, or affiliated with such company by common management or ownership, it may be deemed by the commissioner to have satisfied the aforementioned provisions.

31.2(3) Before any company shall deliver or issue for delivery variable contracts within this state, it shall submit to the commissioner:

a. A general description of the kinds of variable contracts it intends to issue,

b. If requested by the commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable contracts, and

c. If requested, biographical data with respect to officers and directors of the company.

191—31.3(508) Filing, policy forms and provision.

31.3(1) No contract on a variable basis or certificate evidencing variable benefits issued pursuant to any such contract shall be issued or delivered to any person in this state until a copy of the form of the same has been filed pursuant to rule 191—20.1(505,509,514A,515,515A,515F) and approved by the commissioner.

31.3(2) The commissioner shall disapprove or withdraw approval of any such contract form or certificate if:

a. Such contract or certificate contains provisions which are unjust, unfair, inequitable, ambiguous, misleading, likely to result in misrepresentation or contrary to law, or

b. Sales of such contracts are being solicited by any means of advertising, communication or dissemination of information which involves misleading or inadequate description of the provisions of the contract.

c. The contract or certificate does not comply with the filing requirements and provisions set forth in rule 191—20.1(505,509,514A,515,515A,515F).

31.3(3) Any variable contract delivered or issued for delivery in this state and any certificates evidencing variable benefits issued pursuant to any such contract on a group basis shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits and shall state that such dollar amounts will vary to reflect investment experience and shall contain on its first page a clear and prominently placed statement to the effect that the benefits thereunder are on a variable basis.

31.3(4) Illustrations of benefits payable under any contract providing benefits payable in variable amounts shall not include projections of past investment experience into the future or attempted predictions of future investment experience. Hypothetical illustrations of rates to possible levels of annuity payments may be used if submitted to and not disapproved by the commissioner.

31.3(5) No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions which in the opinion of the commissioner are more favorable to the holders of such contracts:

a. A provision that there shall be a period of grace of 30 days or of one month, within which any stipulated payment to the insurer falling due after the first payment may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom.

b. A provision that at any time within one year from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom.

c. A provision specifying the option available in the event of default in a periodic stipulated payment. Such options may include an option to surrender the contract for a cash value as determined by the contract and shall include an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of such paid-up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract.

31.3(6) Any variable contract evidencing variable benefits delivered or issued for delivery in this state shall stipulate the expense, mortality and investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and shall guarantee that expenses will not adversely affect such dollar amounts. In computing the dollar amount of variable benefits or other contractual payments or values under any variable contract, the annual net investment increment assumption shall not exceed 5 percent, except with the approval of the commissioner. "Expenses" as used in this paragraph may exclude some or all taxes, as stipulated in the contract.

31.3(7) To the extent that the level of benefits may be affected by mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the commissioner, from another table.

31.3(8) The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedure that would recognize the variable nature of the benefits provided.

191—31.4(508) Separate account or accounts and investments. Any domestic life insurance company issuing variable contracts shall establish one or more separate or segregated accounts as provided in Iowa Code section 508.32 to invest and reinvest all or any of the amounts received in connection with such variable contracts subject to the following limitations.

31.4(1) Except as hereinafter provided, amounts allocated to any separate or segregated account and accumulation thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; provided, that to the extent that the company's reserve liability with regard to benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest is maintained in any separate or segregated account, a portion of the assets of such separate or segregated account at least equal to such reserve liability shall be, except as the commissioner may otherwise approve,

invested in accordance with laws of this state governing the investments of life insurance companies. The investments in such separate or segregated account or accounts shall not be taken into account in applying the investment limitations applicable to the investments of the company.

31.4(2) With respect to 75 percent of the market value of the total assets in a separate or segregated account, no such company shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate or segregated account in such security taken at market, would exceed 5 percent of the market value of the assets of said separate or segregated account; provided, however, that the commissioner may waive such limitation if in the commissioner's opinion such waiver will not render the operation of such separate or segregated account hazardous to the public or the policyholders in this state.

31.4(3) The separate or segregated account shall not invest in the voting securities of a single issuer in an amount in excess of 10 percent of the total issued and outstanding voting securities of such issuer. The foregoing shall not apply with respect to securities held in separate or segregated accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interests in such accounts.

31.4(4) The limitations in 31.4(2) and 31.4(3) shall not apply to the investments of a separate or segregated account in the securities of an investment company registered under the investment company Act of 1940, provided the investments of such investment companies comply in substance with 31.4(2) and 31.4(3) hereof.

31.4(5) Unless otherwise approved by the commissioner, assets allocated to a separate or segregated account shall be valued at their market value on the date of valuation or, if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate or segregated account; provided, that the portion of the assets of such separate or segregated account equal to the company's reserve liability with regard to the benefits and funds referred to in 31.4(1), if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

31.4(6) The provisions of Iowa Code section 508.8 and any regulations applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate or segregated account's committee, board or other similar body. No officer or director of such company nor any member of the committee, board or body of a separate or segregated account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate or segregated account.

31.4(7) All contracts on a variable basis shall state that the portion of the assets of any such separate or segregated accounts equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

31.4(8) Notwithstanding any other provisions in these rules, a company may:

a. With respect to any separate or segregated account registered with the Securities and Exchange Commission as a unit investment trust exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate or segregated account in accordance with instructions from persons having interests in such accounts ratably as determined by the company, or

b. With respect to any separate or segregated account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the company. Such committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage such account or accounts and the investment of its assets.

A company, committee, board or other body may make such other provisions in respect to any such separate or segregated account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect; provided that the commissioner approves such provisions as not hazardous to the public or the company's policyholders in this state.

31.4(9) No sale, exchange or other transfer of assets may be made by a company between any of its separate or segregated accounts or between any other investment account and one or more of its separate or segregated accounts unless, in case of a transfer into a separate or segregated account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the account to which the transfer is made and unless the transfer, whether into or from an account or accounts, is made by a transfer of cash or by a transfer of securities having a valuation which could be readily determined in the market place, and further provided that the transfer of securities must have been approved by the commissioner. The commissioner may authorize other transfers among such accounts if, in the commissioner's opinion, such transfers would not be inequitable.

31.4(10) The company shall maintain in each such separate or segregated account assets with a value at least equal to the reserves and other contract liabilities with respect to such accounts, except as may otherwise be approved by the commissioner.

This rule is intended to implement Iowa Code sections 505.8 and 508.32.

191—31.5(508) Required reports. Any company issuing individual variable contracts providing benefits in variable amounts shall mail to the contract holder, at least once in each contract year after the first, at the contract holder's last address known to the company, a statement or statements reporting the investments held in the separate or segregated account and, in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four months previous to the date of mailing the number of accumulation units credited to such contracts and the dollar value of a unit or the value of the contract holder's account.

An insurer issuing contracts on a variable basis shall annually on or before March 1 submit to the commissioner an annual statement for the business of its separate or segregated accounts. This statement shall be on such form as may be prescribed by the National Association of Insurance Commissioners and shall include details as to all of the income, disbursements, assets and liability items associated with such account or accounts and such other information as the commissioner of insurance may reasonably require.

191—31.6(508) Producers. No producer shall be eligible to sell or offer for sale a contract on a variable basis unless, prior to making any solicitation or sale of such a contract, the producer is also licensed for the variable products line of authority; however, any producer who participates only in the sale or offering for sale of variable contracts that are not registered under the federal Securities Act of 1933 need not be licensed for the variable products line of authority.

191—31.7(508) Foreign companies. If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the commissioner, to the extent deemed appropriate by the commissioner, may consider compliance with such law or regulation as compliance with these regulations.

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[1] See IAB Insurance Division

CHAPTER 32
DEPOSITS BY A DOMESTIC LIFE COMPANY IN A CUSTODIAN BANK OR CLEARING CORPORATION

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

191—32.1(508) Purpose. These rules implement the authority of insurance companies organized under Iowa Code chapter 508 to make deposits of securities in custodian banks or clearing corporations in order to satisfy the legal reserve requirement imposed on those companies. These rules place requirements on such deposits which are for the protection of policyholders in the state.

191—32.2(508) Definitions. As used in this chapter:

32.2(1) *"Commissioner"* means the commissioner of insurance of the state of Iowa.

32.2(2) *"Company"* means a company organized under Iowa Code chapter 508.

32.2(3) *"Custodial account"* means an account established by agreement between a company and a custodian pursuant to Iowa Code section 511.8, subsection 21, and these rules.

32.2(4) *"Custodial agreement"* means an agreement entered into between a company and a custodian pursuant to these rules.

32.2(5) *"Custodian"* means an institution meeting the requirements of rule 32.4(508) which has entered into a custodial agreement with a company.

32.2(6) *"Custodied securities"* means securities held by or through a custodian when held directly by the custodian or held for the account of the custodian in an authorized clearing corporation or in the federal reserve book entry system.

32.2(7) *"Authorized clearing corporations"* means the following organizations, which are hereby recognized by the commissioner as authorized clearing corporations for purposes of Iowa Code section 511.8, subsection 21, paragraph *"b,"* subparagraph (2), and such other corporations as the commissioner may from time to time designate:

a. Depository Trust Company.
b. Midwest Securities Trust Company.
c. Pacific Securities Depository Trust Company.
d. Philadelphia Depository Trust Company.
e. Euroclear Clearance Ltd.

191—32.3(508) Requirements upon custodial account and custodial agreement. Custodied securities may be used to meet the legal reserve deposit requirements of Iowa Code section 511.8, subsection 16, provided such securities are held under written agreement with a custodian which provides:

32.3(1) That the custodial account is to be titled as follows: "_____ Insurance Company Account No. _____ in custody for and to vest in the Commissioner of Insurance of the State of Iowa in accordance with Iowa Code sections 507C.18 and 508.19".

32.3(2) The commissioner shall notify the custodian, in writing, that a "Minimum Aggregate Value of Securities" must be held in the custodial account at all times. The commissioner's notice remains in full force and effect until amended or revoked in writing by the commissioner. The company shall, on or before the fifteenth day of each month certify to the commissioner on a form provided by the commissioner that the aggregate value (determined as provided by Iowa Code section 511.8, subsection 17) of securities on deposit with the commissioner in the manner specified by Iowa Code section 511.8, subsection 16, and in the custodial account as of the last day of the preceding month was at least equal to the company's legal reserve (as defined in Iowa Code section 511.8) as of the last day of the preceding year. In the event the company fails or refuses to make the certification provided in this subrule, or in the event the commissioner is authorized or directed by reason of any determination, appointment, or order pursuant to Iowa Code section 507C.18, 508.17, 508.18, or 508.22, the commissioner may acquire custody or otherwise assume control of the custodied securities, and may order reregistration, delivery, or other disposition which the commissioner deems appropriate under the circumstances. In

addition, if the commissioner has reason to believe that a company may be insolvent, or that its condition is such as to render its further continuance in business hazardous to the public or holders of its policies, or that continued trading by the company in custodied securities may create a hazard to the public or policyholders, the commissioner may order the company to cease trading in custodied securities pending examination as provided in Iowa Code section 508.16. The company may from time to time deposit or withdraw securities from the custodial account, subject to the stated "Minimum Aggregate Value of Securities" on deposit.

32.3(3) That securities held in a fungible bulk by the custodian and securities in a clearing corporation or in the federal reserve book entry system shall be separately identified on the custodian's official records as being owned by the company. The custodian's records shall identify which custodied securities are held by the custodian and which securities are in a clearing corporation or in the federal reserve book entry system. If the securities are in a clearing corporation, such records shall also identify the name of the clearing corporation, the location of the securities, and, if held through an agent, the name of the agent.

32.3(4) That all custodied securities that are registered must be registered in the name of the company, in the name of a nominee of a company, in the name of the custodian or its nominee, in the name of an agent of the custodian or its nominee, or, if held in a clearing corporation, in the name of the clearing corporation or its nominee.

32.3(5) That during the course of the custodian's regular business hours, the commissioner or the commissioner's representative and authorized employees and representatives of the company, shall be entitled to examine on the premises of the custodian the custodian's records relating to custodied securities of the company.

32.3(6) That the custodian or its agents shall be required to submit to the commissioner, at least annually, or more often as the commissioner may from time to time request, the opinion(s) of an auditor who shall be satisfactory to the commissioner specifically addressing the respective systems of internal account control and record keeping of the custodian or its agents.

32.3(7) That the custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the company's annual statement and supporting schedules as filed with various regulatory authorities and in connection with any audit of the financial statements of the company. Copies of these records shall be delivered to the commissioner upon written request to the custodian.

32.3(8) That the custodian is obligated to indemnify the company for any loss of securities while in its custody occasioned by negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, extortion, or mysterious disappearance, including loss by damage or destruction.

32.3(9) That, in the event there is a loss of the securities for which the custodian is obligated to indemnify the company, the custodian shall promptly replace the same, or the value thereof, and the value of any loss of rights or privileges resulting from said loss of securities and the custodian shall make available to the company for inspection any and all securities or value amounts so replaced.

32.3(10) That minimum levels of deposits of securities at face values totaling $100,000 shall be maintained at all times.

32.3(11) The custodial agreement may contain additional specific operating instructions, controls and provisions concerning the operation of the custodial account provided such operating instructions, controls and provisions are not in conflict with these rules.

32.3(12) Custodial agreements shall be submitted by a company to the commissioner for the commissioner's review prior to execution to ensure compliance with these rules.

32.3(13) That the custodial agreement may be amended or terminated only with the prior approval of the commissioner.

This rule is intended to implement Iowa Code section 511.8(21).

191—32.4(508) Requirements upon custodians. The custodian shall be a bank or trust company having its principal place of business in the United States, selected by the company to act as the custodian under

an agreement authorized by Iowa Code section 511.8, subsection 21, and shall possess the following qualifications:

32.4(1) The custodian shall be audited annually by independent public accountants whose audit report, together with the related financial statements, and opinion on internal controls shall be made available to the company and the commissioner.

32.4(2) The laws governing the custodian shall recognize that the custodied securities remain the specific property of the company, and are not subject to the claim of any third parties arising out of the third party's claim against the custodian.

32.4(3) The custodian shall maintain blanket bond coverage relating to its custodial functions with limits satisfactory to the commissioner.

32.4(4) The custodian's capital and surplus funds shall at all times equal or exceed $25 million and the custodian shall at all times have assets in excess of $500 million, unless the commissioner finds that a particular custodian with less than that amount of funds or assets would possess the requisite stability and soundness to perform the custodial functions without detriment to a company's policyholders.

This rule is intended to implement Iowa Code section 511.8, subsection 21, paragraph *"b."*

191—32.5(508,511) Deposit of securities. Banks or trust companies meeting the requirements of rule 32.4(508) are hereby designated by the commissioner as places for the deposits under Iowa Code sections 508.6 and 511.8(16). Securities required to be deposited under these Iowa Code sections shall no longer be deposited with the commissioner.

This rule is intended to implement Iowa Code sections 508.6 and 511.8, subsection 16.

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CHAPTER 33
VARIABLE LIFE INSURANCE MODEL REGULATION

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

191—33.1(508A) Authority.

33.1(1) This chapter, applicable to variable life insurance policies, is promulgated under the authority of Iowa Code sections 505.8 and 508A.4.

33.1(2) This chapter is supplementary to 191—Chapter 31, which remains in effect except that, with respect to any variable life insurance policy issued on or after the effective date of this chapter, this chapter shall control to the extent there is any conflict.

191—33.2(508A) Definitions. As used in this chapter:

33.2(1) *"Affiliate"* of an insurer means any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

33.2(2) Rescinded IAB 3/24/99, effective 4/28/99.

33.2(3) *"Assumed investment rate"* means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

33.2(4) *"Benefit base"* means the amount to which the net investment return is applied.

33.2(5) *"Commissioner"* means the insurance commissioner of the state of Iowa.

33.2(6) *"Control"* (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management of policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than 10 percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

33.2(7) *"Flexible premium policy"* means any variable life insurance policy other than a scheduled premium policy as specified in subrule 33.2(15).

33.2(8) *"General account"* means all assets of the insurer other than assets in separate accounts established pursuant to Iowa Code section 508A.1 or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

33.2(9) *"Incidental insurance benefit"* means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

33.2(10) *"May"* is permissive.

33.2(11) *"Minimum death benefit"* means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

33.2(12) *"Net investment return"* means the rate of investment return in a separate account to be applied to the benefit base.

33.2(13) *"Person"* means an individual, corporation, partnership, association, trust, or fund.

33.2(14) *"Policy processing day"* means the day on which charges authorized in the policy are deducted from the policy's cash value.

33.2(15) *"Scheduled premium policy"* means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

33.2(16) *"Separate account"* means a separate account established pursuant to Iowa Code section 508A.1 or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

33.2(17) *"Shall"* is mandatory.

33.2(18) *"Variable death benefit"* means the amount of death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

33.2(19) *"Variable life insurance policy"* means any individual policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to Iowa Code section 508A.1 or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

191—33.3(508A) Qualification of insurer to issue variable life insurance. The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having authority to issue variable life insurance in this state.

33.3(1) *Licensing and approval to do business in this state.* An insurer shall not deliver or issue for delivery in this state any variable life insurance policy unless the insurer is licensed or organized to do a life insurance business in this state, and the insurer has obtained the written approval of the commissioner for the issuance of variable life insurance policies in this state. The commissioner shall grant such written approval only after the commissioner has found that:

a. The plan of operation for the issuance of variable life insurance policies is not unsound;

b. The general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably ensure competent operation of the variable life insurance business of the insurer in this state; and

c. The present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things:

(1) The history of operation and financial condition of the insurer;

(2) The qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(3) The applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(4) If the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

33.3(2) *Filing for approval to do business in this state.* The commissioner may, at the commissioner's discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this state, file with this division the following information for the consideration of the commissioner in making the determination required by subrule 33.3(1):

a. Copies of and a general description of the variable life insurance policies it intends to issue;

b. A general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer;

c. With respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the issuer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy shall include a description of the investment objectives intended for the separate account;

d. A description of any investment advisory services contemplated as required by subrule 33.6(10);

e. A copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies;

f. Biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form; and

g. A statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

33.3(3) *Standards of suitability.* Every insurer seeking approval to enter into the variable life insurance business in this state shall establish and maintain a written statement specifying the standards of suitability to be used by the insurer. Such standards of suitability shall specify that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

33.3(4) *Use of sales materials.* An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false, misleading, deceptive, or inaccurate. Variable life insurance sales material, advertising material, and descriptive literature shall be subject to the additional requirements of 191—Chapter 15.

33.3(5) *Requirements applicable to contractual services.* Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the commissioner with any information or reports in connection with such services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with this chapter and any other applicable law or regulations.

33.3(6) *Reports to the commissioner.*

a. Any insurer authorized to transact the business of variable life insurance in this state shall submit to the commissioner, in addition to any other materials which may be required by this chapter or any other applicable laws or regulations:

(1) An annual statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners;

(2) Prior to the use in this state any information furnished to applicants as provided for in rule 33.7(508A);

(3) Prior to the use in this state the form of any of the reports to policyholders as provided for in rule 33.9(508A); and

(4) Such additional information concerning its variable life insurance operations or its separate accounts as the commissioner shall deem necessary.

b. Any material submitted to the commissioner under this subrule shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the commissioner shall require the distribution of amended material.

33.3(7) *Authority of commissioner to disapprove.* Any material required to be filed with and approved by the commissioner shall be subject to disapproval if at any time it is found by the commissioner not to comply with the standards established in this chapter.

191—33.4(508A) Insurance policy requirements. The commissioner shall not approve any variable life insurance form filed pursuant to this chapter unless it conforms to the requirements of this rule.

33.4(1) *Filing of variable life insurance policies.* All variable life insurance policies, and all riders, endorsements, applications and other documents which are to be attached or made a part of the policy and which relate to the variable nature of the policy, shall be filed with the commissioner and approved by the commissioner prior to delivery or issuance for delivery in this state.

a. The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this chapter, the same as those otherwise applicable to other life insurance policies.

b. The commissioner may approve variable life insurance policies and related forms with provisions the commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by this chapter.

c. A filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from its receipt by the division.

33.4(2) *Mandatory policy benefit and design requirements.* Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements:

a. Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

b. For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid (subject to the provisions of subrule 33.4(4), paragraph *"b"*).

c. The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the reflection of investment experience in the variable life insurance policy is actuarially sound.

d. Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

e. Any changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

f. The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other nonforfeiture benefits, as described either in the policy or in a statement filed with the commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values to the minimum values required by Iowa Code section 508.37 (Standard Nonforfeiture Law) for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Nonforfeiture Law of this state. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the Standard Nonforfeiture Law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

g. The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the commissioner.

33.4(3) *Mandatory policy provisions.* Every variable life insurance policy filed for approval in this state shall contain at least the following:

a. The cover page or pages corresponding to the cover page of each such policy shall contain:

(1) A prominent statement in either contrasting color or in bold-faced type that the amount or duration of death benefit may be variable or fixed under specified conditions;

(2) A prominent statement in either contrasting color or in bold-faced type that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(3) A statement describing any minimum death benefit required pursuant to subrule 33.4(2), paragraph *"b"*;

(4) The method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death;

(5) A captioned provision that the policyholder may return the variable life insurance policy within ten days of receipt of the policy by the policyholder, and receive a refund equal to the sum of:

1. The difference between the premiums paid including any policy fees or other charges and the amounts allocated to any separate accounts under the policy; and

2. The value of the amounts allocated to any separate accounts under the policy, on the date the returned policy is received by the insurer or its agent;

(6) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this chapter.

b. Grace period.

(1) For scheduled premium policies, a provision for a grace period of not less than 31 days from the premium due date which shall provide that when the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(2) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amount available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the report to policyholders required by subrule 33.9(3).

The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the policy processing days occur monthly, the insurer may require the payment of not more than three times the charges which were due on the policy processing day on which the amounts available under the policy were insufficient to pay all charges authorized by the policy that are necessary to keep such policy in force until the next policy processing day.

c. For scheduled premium policies, a provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(1) All overdue premiums with interest at a rate not exceeding the legally permissible maximum rate of interest compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding the legally permissible maximum rate of interest compounded annually; or

(2) One hundred ten percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding the legally permissible maximum rate of interest compounded annually.

d. A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

e. A provision designating the separate account to be used and stating that:

(1) The assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account.

(2) The assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

f. A provision specifying what documents constitute the entire insurance contract under state law;

g. A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on behalf of the insured, shall be considered as representations and not warranties;

h. An identification of the owner of the insurance contract;

i. A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation;

j. A statement of any conditions or requirements concerning the assignment of the policy;

k. A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

l. A provision that the policy shall be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the policy's death benefits subsequent to the policy issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, shall be incontestable after any such increase has been in force, during the lifetime of the insured, for two years from the date of issue of such increase;

m. A provision stating that the investment policy of the separate account shall not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the commissioner of this state;

n. A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(1) For up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account, or

(2) Otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical.

o. If settlement options are provided, at least one such option shall be provided on a fixed basis only;

p. A description of the basis for computing the cash value and the surrender value under the policy shall be included;

q. Premiums or charges for incidental insurance benefits shall be stated separately;

r. Any other policy provision required by this chapter;

s. Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this chapter;

t. A provision for nonforfeiture insurance benefits. The insurer may establish a reasonable minimum cash value below which any nonforfeiture insurance options will not be available.

33.4(4) *Policy loan provisions.* Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholder than the following with respect to policy loans after the policy has been in force for five full years:

a. At least 75 percent of the policy's cash surrender value may be borrowed.

b. The amount borrowed shall bear interest at a rate not to exceed that permitted by state insurance law.

c. Any indebtedness shall be deducted from the proceeds payable on death.

d. Any indebtedness shall be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit.

e. For scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within 31 days after the date of mailing of such notice. For flexible premium policies, whenever the total charges authorized by the policy that are necessary to keep the policy in force until the next following policy processing day exceed the amounts available under the policy to pay such charges, a report must be sent to the policyholder containing the information specified by subrule 33.9(3).

f. The policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110 percent of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request.

g. The policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision.

h. No policy loan provision is required if the policy is under an extended insurance nonforfeiture option.

i. The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

j. Amounts paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amounts for policy loans from the general account.

33.4(5) *Other policy provisions.* The following provision may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

a. An exclusion for suicide within two years of the issue date of the policy; provided, however, that to the extent of the increased death benefits only, the policy may provide an exclusion for suicide within two years of any increase in death benefits which results from an application of the owner subsequent to the policy issue date;

b. Incidental insurance benefits may be offered on a fixed or variable basis;

c. Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options:

(1) The amount of the dividend may be credited against premium payments;

(2) The amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(3) The amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(4) The amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(5) The amount of the dividend may be deposited as a variable deposit in a separate account.

d. A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under subrule 33.4(4), except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

e. A provision allowing the policyholder to make partial withdrawals;

f. Any other policy provision approved by the commissioner.

191—33.5(508A) Reserve liabilities for variable life insurance.

33.5(1) Reserve liabilities for variable life insurance policies shall be established under the Standard Valuation Law (Iowa Code section 508.36) in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

33.5(2) For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed

minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

a. The aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

b. The aggregate total of the "attained age level" reserved on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue," as described in subrule 33.5(2), paragraph *"b,"* subparagraph (1), of the prior year's "attained age level" reserve on the contract, with any such "residue," increased or decreased by a payment computed on an attained age basis as described in subrule 33.5(2), paragraph *"b,"* subparagraph (2).

(1) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest in the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(2) The payment referred to in subrule 33.5(2), paragraph *"b,"* shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to A minus B minus C, where A is the present value of the future guaranteed minimum death benefits, B is the present value of the future death benefits that would be payable in the absence of such guarantee, and C is any "residue," as described in subrule 33.5(2), paragraph *"b,"* subparagraph (1), of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal A minus B minus C. The amounts of future death benefits referred to in B shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate or the valuation interest but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

c. The valuation interest rate and mortality table used in computing the two minimum reserves described in subrules 33.5(2), paragraphs *"a"* and *"b,"* shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

33.5(3) For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall be not less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate.

The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

33.5(4) Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

191—33.6(508A) Separate accounts. The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer:

33.6(1) *Establishment and administration of separate accounts.* Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to Iowa Code section 508A.1.

a. If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets shall be in writing and the commissioner shall have authority to review and approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

b. Such insurer shall not without prior written approval of the commissioner employ in any material connection with the handling of separate account assets any person who:

(1) Within the last ten years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Section 1341, 1342, or 1343 of Title 18, United States Code; or

(2) Within the last ten years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(3) Within the last ten years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

c. All persons with access to the cash, securities, or other assets of the separate account shall be under bond in the amount of not less than the greater of the amount required pursuant to Section 17(g) of the Investment Company Act of 1940 or such other amount as the commissioner may deem appropriate.

d. The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

33.6(2) *Amounts in the separate account.* The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

33.6(3) *Investments by the separate account.*

a. No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(1) In case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(2) Such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

b. The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

33.6(4) *Limitations on ownership.*

a. A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after the purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by this chapter, would exceed 10 percent of the value of the assets of the separate account. The commissioner may waive this limitation in writing if the commissioner believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

b. No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts in the aggregate, will own more than 10 percent of the total issued and outstanding voting securities of such issuer. The commissioner may waive this limitation in writing if the commissioner believes the waiver will not render the operation of the

separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of such securities.

c. The percentage limitation specified in subrule 33.6(4), paragraph *"a,"* shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of subrule 33.6(3) and other applicable portions of this chapter.

33.6(5) *Valuation of separate account assets.* Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

33.6(6) *Separate account investment policy.* The investment policy of a separate account operated by a domestic insurer filed under subrule 33.3(2), paragraph *"c,"* shall not be changed without first filing such change with the commissioner.

a. Any change filed pursuant to this rule shall be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of the commissioner's disapproval of the proposed change. At any time the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to this subrule.

b. The commissioner may disapprove the change if the commissioner determines that the change would be detrimental to the interests of the policyholders participating in such separate account.

33.6(7) *Charges against separate account.* The insurer must disclose in writing, prior to or contemporaneously with delivery of the policy, all charges that may be made against the separate account, including, but not limited to, the following:

a. Taxes or reserves for taxes attributable to investment gains and income of the separate account;

b. Actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

c. Actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

d. Charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

e. A charge, at rate specified in the policy, for mortality and expense guarantees;

f. Any amounts in excess of those required to be held in the separate accounts;

g. Charges for incidental insurance benefits.

33.6(8) *Standards of conduct.* Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors a statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct shall be binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17(j) under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of this subrule.

33.6(9) *Conflicts of interest.* Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body.

33.6(10) *Investment advisory services to a separate account.* An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

a. The person providing such advice is registered as an investment advisor under the Investment Advisors Act of 1940; or

b. The person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

c. The insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(1) The name and form of organization, state of organization, and its principal place of business;

(2) The names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

(3) A written standard of conduct complying in substance with the requirements of subrule 33.6(8) which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

(4) A statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

Has been convicted within ten years of any felony or misdemeanor arising out of such person's conduct as an employee, salesperson, officer or director of an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Section 1341, 1342, or 1343 of Title 18 of United States Code;

Has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

Has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws; or

Has been censured, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

d. Such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment advisor.

The commissioner may, after notice and opportunity for hearing, by order require the investment advisory contract to be terminated if the commissioner deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

191—33.7(508A) Information furnished to applicants. An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this rule shall be deemed to have been satisfied to the extent that a disclosure containing information required by this rule is delivered, either in the form of (1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or (2) all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

33.7(1) A summary explanation, in nontechnical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation. Such explanation must include notices of the provision required by subrule 33.4(3), paragraph *"a,"* subparagraph (5), and 33.4(3), paragraph *"f."*

33.7(2) A statement of the investment policy of the separate account, including:

a. A description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

b. Any restrictions or limitations on the manner in which the operations of the separate account are intended to be conducted.

33.7(3) A statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence.

33.7(4) A statement of the charges levied against the separate account during the previous year.

33.7(5) A summary of the method to be used in valuing assets held by the separate account.

33.7(6) A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder, and the beneficiary.

33.7(7) Illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is made clear that such assumed rates are hypothetical only.

191—33.8(508A) Applications. The application for a variable life insurance policy shall contain:

33.8(1) A prominent statement that the death benefit may be variable or fixed under specified conditions.

33.8(2) A prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees).

33.8(3) Questions designed to elicit information which enable the insurer to determine the suitability of variable life insurance for the applicant.

191—33.9(508A) Reports to policyholders. Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at the policyholder's last known address the following reports.

33.9(1) Within 30 days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefits, any partial withdrawal or policy loan, any interest charge, any optional payments allowed pursuant to subrule 33.4(4) under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within 30 days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than 60 days prior to the mailing of the notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this rule. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. In addition, the report must show the projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report assuming that: (i) Planned periodic premiums, if any, are paid as scheduled; (ii) guaranteed costs of insurance are deducted; and (iii) the net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

33.9(2) Annually, a statement or statements including:

a. A summary of the financial statement of the separate account based on the annual statement last filed with the commissioner;

b. The net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

c. A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the commissioner;

d. Any charges levied against the separate account during the previous year;

e. A statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment advisor of the separate account.

33.9(3) For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of such amount.

191—33.10(508A) Foreign companies. If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by this chapter, the commissioner to the extent deemed appropriate in the commissioner's discretion, may consider compliance with such law or regulation as compliance with this chapter.

191—33.11(508A) Qualifications of agents for the sale of variable life insurance. Rescinded IAB 3/24/99, effective 4/28/99.

191—33.12(508A) Separability article. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code chapter 508A.

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[1] See IAB Insurance Division

CHAPTER 34
NONPROFIT HEALTH SERVICE CORPORATIONS
[Prior to 10/22/86, Insurance Department[510]]

191—34.1(514) Purpose. The purpose of this chapter is to specify those requirements imposed upon health service corporations under Iowa Code chapter 514 and delineate standards for the commissioner's implementation of these requirements.

191—34.2(514) Definitions. For purposes of this chapter, the following definitions shall apply:

"Commissioner" means the commissioner of insurance for the state of Iowa.

"Competitor" means a corporation, business entity, or person engaged in the business of contracting to provide health care services to others, pay indemnity for health care services provided to others, or provide administrative services relevant thereto in the state of Iowa.

"Division" means the insurance division of Iowa.

"Employee" is as defined by Iowa Code section 85.61.

"Health care services" means services included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of all other services for the purposes of preventing, alleviating, curing or healing human illness, injury, or physical disability.

"Immediate family member" means an individual within the first degree of consanguinity or affinity who resides in the same household. With respect to determining the immediate family or spouse of a provider, only those providers licensed and practicing in Iowa on a regular basis shall be considered.

"Material financial interest" means a vested interest of at least 10 percent of the fair market value of the property or an interest from which at least 10 percent of individual's gross income is derived.

"Provider" means any physician, hospital, or person as defined in Iowa Code chapter 4 which is licensed or otherwise authorized in the state of Iowa to furnish health care services.

"Related industry" means a commercial enterprise whose goods or services are by design or function primarily for use in the health care services industry. Related industry does not include commercial enterprises whose goods and services are generic to business in general, such as, but not limited to, utilities, food, cleaning, financial, or legal services.

"Subscriber" means an individual who enters into a contract for hospital services, medical or surgical services, dental services, pharmaceutical services, or optometric services with a corporation subject to Iowa Code chapter 514. With respect to contracts providing benefits to more than one individual, subscriber shall include each individual entitled to receive benefits who has reached the legal age of majority. Subscriber also includes all individuals entitled to receive services or payment for services from a corporation subject to Iowa Code chapter 514 pursuant to the terms of a contract or certificate issued by the corporation to an employer or group. Subscriber also includes any individual eligible for medical assistance or additional medical assistance as defined by Iowa Code chapter 249A and with respect to whom the department of human services has entered into a contract with the corporation subject to Iowa Code chapter 514.

"Subscriber director" means a subscriber who is a member of the board of directors of a corporation subject to Iowa Code chapter 514 and who is not a provider, the spouse or an immediate family member of a provider. Subscriber director includes only those individuals nominated pursuant to subrule 34.7(2). Subscriber director does not include any individual who has a material financial interest or fiduciary interest in the delivery of health care services or a related industry, an employee of an institution which provides health care services, or the spouse or an immediate family member of such an individual. A subscriber director of a hospital or medical service corporation shall be a subscriber of the services of that corporation. Proof of compliance with the requirements of this paragraph shall be by affidavit.

191—34.3(514) Annual report requirements. Each corporation subject to Iowa Code chapter 514 shall file an annual statement on the National Association of Insurance Commissioner's annual statement blank.

This rule is intended to implement Iowa Code section 514.9.

191—34.4(514) Arbitration. Parties defined in Iowa Code section 514.13 may submit covered disputes to the commissioner. The following procedures shall be followed when covered disputes are submitted to the commissioner.

34.4(1) The party seeking arbitration shall file a petition for arbitration requesting arbitration by the commissioner and setting forth the facts which are the basis for the dispute, together with a statement of the factual or legal issue(s), and the party's position on the issue(s), and serve a copy of the petition by certified mail upon the other party(ies) to the dispute. Proof of service shall be promptly filed with the commissioner.

34.4(2) The other party(ies) shall file within 20 days an answer to the petition for arbitration, admitting or denying the facts alleged in the petition and indicating whether there is agreement with the statement of the issue(s) in the petition and setting forth the other party's position on the issue(s). All papers other than the petition shall be served in accordance with Iowa Rule of Civil Procedure 82 with proof of service to be made in conformance therewith.

34.4(3) The commissioner shall conduct a prehearing conference in accordance with rule 191—3.5(17A,502,505) at which the commissioner may set a schedule for the submission of briefs by the parties, and, if necessary, shall provide for the holding of an evidentiary hearing. The parties are encouraged to stipulate to the facts and agree as to the legal issue(s).

34.4(4) The commissioner may submit the dispute to a person selected by the commissioner, who may or may not be employed by the division, who shall make proposed findings and recommendations to the commissioner for a decision by the commissioner.

191—34.5(514) Filing requirements. All matters subject to the division's approval under Iowa Code chapter 514 shall be submitted pursuant to rule 191—20.1(505,509,514A,515,515A,515F) prior to the intended effective date.

191—34.6(514) Participating hospital contracts.

34.6(1) The following standards shall be applied to all participating hospital contracts subject to approval under Iowa Code section 514.8 and shall be relied upon by the commissioner in deciding whether approval is granted:

a. Contracts shall be fair to the subscribers of the hospital service corporation.

b. Contracts shall be fair to the hospital service corporation.

c. Contracts shall be fair, reasonable, and in the public interest.

d. The subscribers' rights to service under participating hospital contracts shall be adequately specified and protected.

e. The contract shall not be unfairly discriminatory with respect to the provision of services to subscribers.

f. Contracts shall not be detrimental to the financial condition of the hospital service corporation.

g. The payment of consideration required of the hospital service corporation by the provisions of the contract shall not be excessive, inadequate or unfair.

34.6(2) The prototype contract used by hospital service corporations with participating hospitals for hospital service shall be subject to the prior approval of the division. The individual contracts between hospital service corporations and individual participating hospitals are not subject to prior approval, so long as they substantially conform to the prototype contract approved by the commissioner. An informational filing shall be required upon execution of an individual hospital contract. An individual hospital contract shall be deemed to be in substantial conformity with the prototype contract if it is not disapproved within 30 days of filing.

34.6(3) In order to ensure fair and equitable charges to and premiums paid by subscribers of hospital service corporations, any method for paying hospitals which is contained in contracts between hospital service corporations and participating hospitals shall contain the following:

a. Incentives for high productivity and disincentives that encourage efficiency in hospital operation and effectiveness in use;

b. Provisions for economic trends;

c. Adjustments for variations in capacity among large hospitals and small hospitals;

d. Control mechanisms on unnecessary utilization and inappropriate setting for care;

e. Payment levels to hospitals which are equitable and meet reasonable financial requirements;

f. An internal appeal mechanism for disputes relating to budget review.

This rule is intended to implement Iowa Code chapter 514.

191—34.7(514) Composition, nomination, and election of board of directors.

34.7(1) *Composition of board of directors.* The composition of the board of directors of each corporation subject to Iowa Code chapter 514 shall be as follows:

a. On and after August 1, 1984, a majority of the members of the board of directors of each corporation subject to Iowa Code chapter 514 shall be subscriber directors.

b. On and after August 1, 1985, at least two-thirds of the members of the board of directors of each corporation subject to Iowa Code chapter 514 shall be subscriber directors.

34.7(2) *Nomination of subscriber directors.*

a. Until the board composition requirements of subrule 34.7(1), paragraph *"b,"* are met, a ballot containing nominees for subscriber director positions shall be prepared by an independent subscriber nominating committee pursuant to subrule 34.7(3). Nominations for subscriber director positions may also be made by petition signed by at least 50 subscribers. The independent subscriber nominating committee shall consider the petitions to determine which persons, if any, nominated by those petitions shall be placed on the ballot.

b. Once the board composition requirements of subrule 34.7(1), paragraph *"b,"* are met, a ballot containing nominees for subscriber director position shall be prepared by the subscriber directors under procedures established by the board of directors. These procedures shall also permit nomination by a petition of at least 50 subscribers. The board shall determine which persons, if any, nominated by these petitions shall be placed on the ballot.

34.7(3) *Independent subscriber nominating committee.*

a. Generally. An independent subscriber nominating committee shall be appointed for each corporation subject to Iowa Code chapter 514. Each independent subscriber nominating committee shall consist of at least five to seven members. Commonality of membership among the independent subscriber nominating committees shall be permissible. The independent subscriber nominating committee for each corporation shall, as a whole, be broadly representative of the subscribers of the corporation. The independent subscriber nominating committee for each corporation shall serve only until the composition of the board of directors for the corporation meets the requirements of subrule 34.7(1), paragraph *"b."*

b. Standards for independent subscriber nominating committee membership. Each individual appointed to the independent subscriber nominating committee shall meet the following criteria:

(1) Each member of an independent subscriber nominating committee shall be a subscriber of a corporation subject to Iowa Code chapter 514. Each member of the independent subscriber nominating committee of a hospital or medical service corporation shall be a subscriber of the services of that corporation.

(2) No member of an independent subscriber nominating committee shall be a member of the board of directors of a corporation subject to Iowa Code chapter 514.

(3) No member, their spouse or an immediate family member, of an independent subscriber nominating committee shall have a material financial interest in, be a fiduciary to, or be an employee of a competitor. Proof of compliance with this requirement shall be by affidavit.

(4) Each member of an independent subscriber nominating committee shall have reasonable knowledge of the operation of and issues facing the corporation for which the independent subscriber nominating committee has been appointed.

c. Appointment. The commissioner shall appoint each committee from names suggested by individual subscribers, group subscribers, labor organizations, the Health Policy Corporation of Iowa, each corporation subject to Iowa Code chapter 514, and other interested persons. Interested persons shall submit the names of potential independent subscriber nominating committee members to the commissioner within 30 days of the effective date of these rules. The committee appointments will be within 7 days thereafter.

d. Work of the independent subscriber nominating committee. The independent subscriber nominating committee shall develop a ballot containing nominees for subscriber director positions to be filled. At least two and not more than three individuals shall be nominated for each subscriber director position to be filled.

The independent subscriber nominating committee shall also consider each individual currently serving as a subscriber representative on the board of directors of a corporation operating pursuant to Iowa Code chapter 514, and each individual nominated by subscriber petitions, for inclusion on the ballot containing nominees for subscriber directors. The independent subscriber nominating committee shall select nominees that represent a broad spectrum of subscriber interests including an appropriate balance of demographic and geographic characteristics for the corporation's service area.

e. Criteria for nominees. The independent subscriber nominating committee shall utilize the following criteria in developing nominations for subscriber directors:

(1) Each nominee shall be a subscriber of a corporation subject to Iowa Code chapter 514. Each nominee to the board of directors of a hospital or medical service corporation shall be a subscriber of the services of that corporation. The corporation shall verify a potential nominee's subscriber status upon inquiry by an independent subscriber nominating committee.

(2) A nominee, their spouse or an immediate family member, shall not have a material financial interest in, be a fiduciary to, or be an employee of a competitor or provider. Proof of compliance with this requirement shall be by affidavit.

(3) Each nominee shall have reasonable knowledge of the operation of and issues facing the corporation to whose board the nominee has been nominated.

34.7(4) *Election of subscriber directors.* Each subscriber director shall be elected from the subscriber nominees placed on a ballot prepared as provided by these rules. The ballot shall alphabetically list the subscriber nominees and indicate that each member shall vote only for the same number of candidates as there are positions to be filled. Election shall be by the corporate membership. Nominees receiving the most votes shall be considered elected to the positions.

The ballot for electing subscriber directors may also contain nominees to be elected to provider director positions.

34.7(5) *Nomination of provider directors.*

a. Until the board composition requirements of subrule 34.7(1), paragraph *"b,"* are met, nominations for provider director positions may be made by petition signed by at least 50 providers. The independent subscriber nominating committee shall consider the petitions to determine which persons, if any, nominated by those petitions shall be placed on the ballot.

b. Once the board composition requirements of subrule 34.7(1), paragraph *"b,"* are met, the board of directors shall establish procedures to permit nomination of provider directors by petition of at least 50 participating providers. The board of directors shall consider the petitions to determine which persons, if any, nominated by those petitions shall be placed on the ballot.

c. This subrule shall not be construed to preclude nominations for provider director positions by any alternate means provided by the corporation's articles or bylaws.

34.7(6) *Construction.* The articles or bylaws of a corporation operating pursuant to Iowa Code chapter 514 shall continue in existence to the extent that they do not conflict with this rule.

This rule is intended to implement Iowa Code section 514.4.

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CHAPTER 35
ACCIDENT AND HEALTH INSURANCE

BLANKET ACCIDENT AND SICKNESS INSURANCE

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

191—35.1(509) Purpose. The purpose of this regulation is to establish guidelines for insurers to make special risk coverage available to particular groups that will be exposed to specific hazards for a certain period of time.

191—35.2(509) Scope. These rules 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 and 515.

191—35.3(509) Definitions.

35.3(1) Blanket accident and sickness insurance is hereby declared to be that form of accident, sickness or accident and sickness insurance designed to insure against specified hazards incident to or defined by reference to a particular activity or activities and covering groups of persons as enumerated in the following subparagraphs:

a. Under a policy issued to an employer, who shall be deemed the policyholder covering any group of employees defined by reference to specific hazards incident to an activity or activities of the policyholder.

b. Under a policy issued to a college, high school, junior high school, grade school, school district, school jurisdictional unit or other institution of learning; or to the head, principal, governing board of any such educational unit who or which shall be deemed the policyholder covering students, teachers or employees.

c. Under a policy issued to any religious, charitable or educational organization, or branch thereof, which shall be deemed the policyholder covering any group of members or participants defined by reference to specified hazards incident to an activity or activities sponsored or supervised by such policyholder.

d. Under a policy issued to a sports team, youth camp, recreational organization or sponsor thereof, which shall be deemed the policyholder, covering members, campers, participants, employees, officials or supervisors.

e. Under a policy issued to any volunteer fire department, first aid, civil defense or other such volunteer organizations, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

f. Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

g. Under a policy issued to an association, other than a labor union, trade association or industrial association, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

h. Under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

35.3(2) Brochure shall mean an instrument, booklet or pamphlet setting forth a statement as to the insurance protection provided, to whom the insurance benefits are payable, sufficient information on the procedure an insured shall follow in filing a claim and such other provisions as are in the opinion of the commissioner of insurance necessary to inform the holder thereof as to rights under the policy.

35.3(3) For purposes of 2005 Iowa Acts, House File 420, section 1, relating to biologically based mental illness coverage in a group policy, contract or plan providing for third-party payment of health, medical, and surgical coverage benefits issued by a carrier or by an organized delivery system,

"biologically based mental illness" shall mean the following mental disorders as they are defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

a. Schizophrenia. Diagnostic codes 295.xx and 293.xx, including all specific subtypes of schizophrenia listed under those two diagnostic codes and using an appropriate extension. Schizophrenia also includes diagnostic codes 295.40, 295.70, 297.1, 298.8, 297.3 and 298.9.

b. Bipolar disorders. Diagnostic code 296.xx including all specific subtypes of bipolar disorders listed under that diagnostic code and using an appropriate extension. Bipolar disorders also includes diagnostic codes 286.89, 301.13, 296.80, 293.83 and 296.90.

c. Major depressive disorders. Diagnostic codes 296.2x and 296.3x including all specific subtypes of major depressive disorders listed under those two diagnostic codes and using an appropriate extension.

d. Schizo-affective disorders. Diagnostic code 295.70.

e. Obsessive-compulsive disorders. Diagnostic code 300.3.

f. Pervasive development disorders. Diagnostic codes 299.00, 299.80 and 299.10.

g. Autistic disorders. Diagnostic code 299.00.

191—35.4(509) Required provisions. No blanket policy as herein defined shall be issued or delivered in this state unless a copy of the policy and brochure if required, has been approved by the commissioner of insurance in accordance with the provisions set forth in rule 35.7(509). All policies of blanket accident or sickness insurance or combination thereof issued in this state shall contain in substance the following provisions:

35.4(1) A provision that the policy including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense of a claim under the policy, unless it is contained in a written application. If a copy of such application is not delivered to the person insured the insurer shall be precluded from introducing such application as evidence in any action involving any statements contained therein.

35.4(2) A provision that written notice of sickness or of injury must be given to the insurer within 20 days of the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

35.4(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after giving such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

35.4(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

35.4(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

35.4(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

35.4(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

191—35.5(509) Application and certificates not required. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate; however, a brochure as herein defined shall be issued to the policyholder for delivery to each person insured as defined in 35.3(1)*"b"* and *"g."*

191—35.6(509) Facility of payment. All benefits under any blanket accident and sickness policy shall be payable to the person insured, to a designated beneficiary or beneficiaries, or to their estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to their parent, guardian or other person actually supporting the insured, designated beneficiary, or beneficiaries. The policy may also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may with the consent of the insured be paid directly to the hospital or person rendering such services, but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid.

These rules are intended to implement Iowa Code section 509.6.

191—35.7(509) General filing requirements.

35.7(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings pursuant to rule 191—20.1(505,509,514A,515,515A,515F).

35.7(2) Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

191—35.8(509) Electronic delivery of accident and health group insurance certificates.

35.8(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by insurers and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 509.3(2), and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

35.8(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 and 515.

35.8(3) *Electronic delivery—insurance companies.* The insurer will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The insurer takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the insurer furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

35.8(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 509.

191—35.9 to **35.19** Reserved.

191—35.20(509A) Life and health self-funded plans.

35.20(1) Scope. This rule shall apply to life and health self-funded plans for political subdivisions of the state, school corporations, and all other public bodies of the state. This rule shall not apply to life and health self-funded plans for the state of Iowa.

35.20(2) Iowa Code chapter 28E agreements—certificate of registration. Public entities seeking to pool risk through a joint exercise of power under Iowa Code chapter 28E shall apply for and obtain a certificate of registration from the commissioner. This subrule shall not apply to single-employer public entities with self-insured plans.

a. An application for a certificate of registration shall contain the following:

(1) A copy of the proposed agreement entered into pursuant to Iowa Code chapter 28E, to be executed by all plan participants;

(2) A copy of the articles of incorporation, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees and beneficiaries;

(3) A copy of all contracts with insurance companies, consultants and third-party administrators;

(4) A business plan, including a copy of all contracts or other instruments which the 28E agreement proposes to make with or sell to its members, a copy of its plan description and the printed matter to be used in the solicitation of members; and

(5) A current list of all participating public entities.

b. Iowa Code chapter 28E agreements shall contain the following provisions:

(1) If the plan is in a deficit position, a participant cannot terminate from the plan without the prior written consent of the commissioner;

(2) If a participant in the plan terminates, the terminating participant shall be assessed its proportionate share of the plan's deficit, if any;

(3) Deficit assessments shall be mandatory for all plan participants within a time frame acceptable to the commissioner;

(4) Plan participants have no individual interest in the accumulated surplus of a plan; and

(5) Upon termination of the plan, surplus remaining after the payment of all liabilities shall be distributed proportionately to plan participants that were active members of the plan on the termination date.

c. Reporting requirements. In addition to the requirements of subrule 35.20(3), all public entities pooling risk shall submit:

(1) Quarterly financial statement. A plan shall file with the commissioner of insurance within 60 days of the end of each quarter a report which has been verified by at least two of its principal officers and which covers the preceding calendar quarter. The report shall be on a form prescribed by the commissioner. The commissioner of insurance may request additional reports and information from a plan as often as is deemed necessary.

(2) Amendments. A plan shall submit copies of any proposed amendment to the documents submitted in accordance with subrule 35.20(2), paragraph *"a,"* 30 days in advance of the amendment's proposed effective date.

(3) Other documents. A plan shall submit any other documents deemed necessary by the commissioner.

35.20(3) Minimum plan standards for both pooled and single-employer public entities. Self-funded life plans subject to this rule shall meet the requirements of Iowa Code sections 509.1, 509.2, 509.4, and 509.15 and rules thereunder. Self-funded health plans subject to this rule shall meet the requirements of Iowa Code sections 509.1 and 509.3 and rules thereunder. In order to ensure that a self-funded life or health plan is able to cover all reasonably anticipated expenses and to avoid liability for the public body, a self-funded life or health plan shall provide that:

a. An annual report showing the starting and ending balance of the fund, deposits of monthly accrual rates and other assets of the fund, and the amount and nature of all disbursements from the fund shall be prepared and submitted to the governing body of the public body. An annual report shall be made to show a separate accounting to reflect all required reserves.

b. Monthly accrual rates shall be established at a satisfactory level to provide funds to cover all claims, reserves, and expenses to operate the plan. Accrual rates shall be reevaluated annually. Accrual rates shall be funded solely through public body contributions or through a combination of employer and employee contributions.

c. A plan fund shall be established exclusively for the deposit of monthly accrual rates and other assets pertaining to the plan. After a self-funded life or health plan is established and as long as any claims may be made against the plan fund, all contributions shall be deposited as collected in the plan fund. The plan fund shall be disbursed only for plan expenses.

d. The following reserves shall be established in the plan fund:

(1) A reserve for claims that have been incurred by participants under the plan, but have not yet been presented for payment. The appropriate amount of this reserve shall be on an actuarially sound basis as determined by an independent actuary, an insurance company, or a nonprofit health service corporation authorized pursuant to Iowa Code chapter 514.

(2) A claims fluctuation reserve for setting aside funds that become available during a month when claims are less than projected for that month. Funds shall be maintained and available for a month in which claims exceed those projected for that month. For public entities that require a certificate of registration under subrule 35.20(2), the claims fluctuation reserve shall equal or exceed a minimum of two months of paid claims.

e. The public body shall obtain a fidelity bond as a guaranty of faithful operation of the self-funded plan by the public body, its officers, agents, and employees.

f. Disbursements from the plan fund shall be made only for the following specified plan expenses:

(1) Payment of claims.

(2) Cost of aggregate excess loss coverage.

(3) Cost of specific excess loss coverage.

(4) Bonding expenses.

(5) Payment of service fees applicable to plan design, payment of claims, materials explaining plan benefits, actuarial assistance, legal assistance, and accounting assistance.

(6) Other expenses directly related to the operation of the plan.

g. Aggregate excess loss coverage shall be obtained which will limit a public body's total claim liability for each year to not more than 125 percent of the level of claims liability as projected by an independent actuary or insurance company. A public body shall fund this potential additional liability of 25 percent either by allocating necessary funds from the operating fund of the general fund or by setting up an additional reserve in the operating fund. Specific excess loss coverage may also be obtained if a public body wishes to limit its total annual liability on claims for any one claimant.

h. The commissioner may retain an independent actuary, at the commissioner's discretion, to review the adequacy of a plan's reserves. The cost of such review shall be paid by the plan. Examples that illustrate when the commissioner may retain an independent actuary include, but are not limited to, negative trends in the plan's financial statements, an increase in consumer complaints about the plan's failing to timely pay claims and material changes to the plan's operations.

35.20(4) Plan shortfalls. If the resources of any self-funded plan subject to this rule are not adequate to fully cover all claims under that plan, then the public body sponsoring that plan shall make up the shortfall from other resources.

35.20(5) Confidentiality. Information held by the plan administrator of a self-funded plan shall be kept confidential. An employee or agent of the plan administrator shall not use or disclose any information to any person, except to the extent necessary to administer claims or as otherwise authorized by law.

35.20(6) A health self-funded plan subject to this rule shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of a self-funded plan's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the self-funded plan or a person contracting with the self-funded plan.

The self-funded plan shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the self-funded plan that, in the opinion of the provider, jeopardizes patient health or welfare.

35.20(7) Benefits shall be made available by the health self-funded plan for inpatient and outpatient emergency services. Since self-funded plans may not contract with every emergency care provider in an area, self-funded plans shall make every effort to inform members of participating providers.

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

Reimbursement to a provider of "emergency services" shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial diagnosis as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that a noncontracted provider performed services. If reimbursement for emergency services is denied, the enrollee may file a complaint with the self-funded plan. Upon denial of reimbursement for emergency services, the

self-funded plan shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

35.20(8) A health self-funded plan subject to this rule shall allow a female member direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

This rule is intended to implement Iowa Code chapter 509A and 2003 Iowa Acts, chapter 83.

191—35.21(509) Review of certificates issued under group policies.

35.21(1) *Nondiscretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state.

35.21(2) *Discretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group not substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state and if the policy is issued or offered in a state which has reviewed and approved the policy under a statute substantially similar to Iowa Code section 509.1(8).

These rules are intended to implement Iowa Code sections 509.1, 509.6, and 509A.14.

LARGE GROUP HEALTH INSURANCE COVERAGE

191—35.22(509) Purpose. This division of Chapter 35 implements the requirements of Pub.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 and Iowa Code section 509.3 for large group health insurance coverage.

191—35.23(509) Definitions.

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

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

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

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

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

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

"Commissioner" means the commissioner of insurance.

"Continuation coverage" means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar

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

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

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

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

"Division" means the division of insurance.

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

"Employee" means any individual employed by an employer.

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

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

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

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

1. For purposes of this rule, "medical care" means amounts paid for any of the following:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
- Transportation primarily for and essential to medical care referred to in this definition.
- Insurance covering medical care referred to in this definition.

2. For purposes of this division, a plan, fund, or program established or maintained by a partnership which, but for this paragraph, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, for present or former

partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

3. With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

4. With respect to a group health plan the term "participant" includes the following:

- With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.
- With respect to a group health plan maintained by a self-employed individual, under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

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

1. "Health insurance coverage" does not include any of the following:

- Coverage for accident only, or disability income insurance.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinic care.
- Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- Flexible spending accounts.

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

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

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

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

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

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

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

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

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

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

"Organized delivery system" or *"ODS"* means an organized delivery system licensed by the director.

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

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

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

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's consent, that is, within 12 months of the date the contract becomes effective.

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

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

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

191—35.24(509) Eligibility to enroll.

35.24(1) A carrier or an organized delivery system offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.
b. Medical condition, including both physical and mental conditions.
c. Claims experience.
d. Receipt of health care.
e. Medical history.
f. Genetic information.
g. Evidence of insurability, including conditions arising out of acts of domestic violence.
h. Disability.

35.24(2) Subrule 35.24(1) does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from

establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

35.24(3) Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting or affiliation periods for such enrollment.

35.24(4) A carrier or organized delivery system offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage. This subrule shall not be construed to do either of the following:

a. Restrict the amount that an employer may be charged for health insurance coverage.

b. Prevent a carrier or organized delivery system offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

35.24(5) A carrier or organized delivery system shall not modify a health insurance coverage with respect to an employer or any eligible employee or dependent through riders, endorsements or other means, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the health insurance coverage.

191—35.25(509) Special enrollments.

35.25(1) A carrier or organized delivery system shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health insurance coverage, if an eligible employee requests enrollment or, if the group health insurance coverage makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health insurance coverage, during the special enrollment period, which shall be 30 days following an event described in subrules 35.25(2) or 35.25(3) with respect to the individual for whom enrollment is requested. A carrier or organized delivery system may impose enrollment requirements that are otherwise applicable under terms of the group health insurance coverage to individuals requesting immediate enrollment.

35.25(2) An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health insurance coverage, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health insurance coverage, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health insurance coverage, group health plan, or otherwise; and

b. When enrollment was declined for the individual:

(1) The individual had coverage under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

c. For purposes of subparagraph 35.25(2)*"b"*(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health insurance coverage; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

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

35.25(3) If the eligible employee has previously declined enrollment under the group health insurance coverage but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

35.25(4) Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

191—35.26(509) Group health insurance coverage policy requirements.

35.26(1) Group health insurance coverage subject to the rules in this division is renewable with respect to all eligible employees or their dependents at the option of the employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay or to make timely payments of premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsors, performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's or organized delivery system's minimum participation requirements or employer contribution requirements.

d. For a network plan, no enrollees connected to the plan live, reside, or work in the service area of the issuer.

e. A carrier or ODS may choose to discontinue offering and cease to renew a particular type of health insurance coverage in the large group market if the carrier does all of the following:

(1) Provides advance notice of its decision to discontinue the plan to the commissioner or director a minimum of three days prior to the notice for affected employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew a plan to all affected employers, participants, and beneficiaries no less than 90 days prior to nonrenewal of a plan.

(3) Offers to each plan sponsor of the discontinued coverage the option to purchase any other coverage currently offered by the carrier or ODS to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph 35.26(1)*"e"*(3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier or ODS to discontinue offering and cease to renew all of its health insurance delivered or issued for delivery to employers in this state shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph 35.26(1)*"f"*(2) to affected employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected employers, participants, and beneficiaries no less than 180 days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to employers in this state and cease renewal of such coverage.

g. The membership of an employer in a bona fide association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this subrule occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner or director finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's or ODS's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier or ODS may modify the health insurance coverage for a product offered under group health insurance coverage in the group market, if such modification is consistent with the laws of this state and is effective on a uniform basis among group health insurance coverage with that product.

35.26(2) A carrier or ODS that elects not to renew health insurance coverage under 35.26(1)*"f"* shall not write any new business in the group market in this state for a period of five years after the date of notice to the commissioner or director.

35.26(3) This rule applies only to a carrier or ODS doing business in one established geographic service area of the state and the carrier's or ODS's operations in that service area.

35.26(4) Preexisting condition exclusions.

a. A carrier or ODS, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier or ODS offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier or ODS shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this paragraph, "affiliation period" means a period of time not to exceed 60 days for new entrants and not to exceed 90 days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors.

d. A group health plan, carrier, or ODS offering group health insurance under the plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant under rule 35.29(509).

191—35.27(509) Methods of counting creditable coverage.

35.27(1) For purposes of reducing any preexisting condition exclusion period, a group health plan, carrier, or ODS offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in paragraph 35.27(1)*"a,"* except that the

plan, carrier or ODS may use the alternative method under paragraph 35.27(1)*"b"* with respect to any or all of the categories of benefits described under paragraph 35.27(1)*"d."*

a. Under the standard method, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

(1) For purposes of reducing the preexisting condition exclusion period, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(2) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(3) Notwithstanding any other provisions of paragraph 35.27(1)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 35.27(1)*"b."*

b. Under the alternative method, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in paragraph 35.27(1)*"d"* and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 35.27(1)*"a."*

c. A plan, carrier, or ODS using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

d. The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(1) Mental health.

(2) Substance abuse treatment.

(3) Prescription drugs.

(4) Dental care.

(5) Vision care.

e. If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

(3) Count creditable coverage within a category if any level of benefits is provided within the category.

191—35.28(509) Certificates of creditable coverage.

35.28(1) Group health plans, carriers, or ODSs shall issue certificates of creditable coverage to persons losing coverage. A group health plan, carrier, or ODS required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. Automatically upon the termination of an individual's group coverage;

b. Automatically upon the termination of COBRA coverage;

c. Upon request within 24 months after coverage ends.

35.28(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. The individual requesting the certificate is not entitled to receive a certificate;

b. The individual requests that the certificate be sent to another plan, carrier, or ODS;

c. The plan, carrier, or ODS receiving the certificate agrees to accept the information through means other than a written certificate;

d. The plan or carrier receiving the certificate receives the certificate within a reasonable amount of time.

35.28(3) Required information. The certificate shall include the following information:

a. The date the certificate is issued;

b. The name of the group plan providing coverage;

c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;

d. The plan administrator's name, address and telephone number;

e. A telephone number to call for further information if different from above;

f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;

g. The date creditable coverage ended or an indication that the coverage is in force.

35.28(4) Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

35.28(5) Dependent coverage transition rule. A group health plan, carrier, or ODS that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

35.28(6) Delivering certificates. The certificate shall be given to the individual, plan, carrier, or ODS requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

35.28(7) A group health plan, carrier, or ODS shall establish a procedure for individuals to request and receive certificates.

35.28(8) A certificate is not required to be furnished until the group health plan, carrier, or ODS knows or should have known that dependent's coverage terminated.

35.28(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan, carrier, or ODS shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

191—35.29(509) Notification requirements.

35.29(1) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents that includes the following:

a. The existence of any preexisting condition exclusions.

b. A determination that the group health plan, carrier, or ODS intends to impose a preexisting condition exclusion and:

(1) The basis for the decision to do so;

(2) The length of time to which the exclusion will apply;

(3) The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion;

(4) The right of the person to demonstrate creditable coverage including the right of the person to request a certificate from a prior group health plan, carrier, or ODS and a statement that the current group health plan, carrier, or ODS will assist in obtaining the certificate.

c. That the group health plan, carrier, or ODS will use the alternative method of counting creditable coverage.

d. Special enrollment rights when an employee declines coverage for the employee or dependents.

35.29(2) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of a modification of a prior creditable coverage decision when the group health plan, carrier, or ODS subsequently determines either no or less creditable coverage existed provided that the group health plan, carrier, or ODS acts according to its initial determination until the final determination is made.

191—35.30(509) Mental health benefits. Rescinded IAB 12/7/05, effective 1/11/06.

191—35.31(509) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all carriers and ODSs offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers and ODSs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—35.32(514C) Treatment options.

35.32(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

35.32(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—35.33(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

35.33(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

35.33(2) The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

35.33(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier without that organization's review of the patient's medical history, presenting symptoms, and admitting

or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the carrier. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—35.34(514C) Provider access. A carrier subject to this chapter shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The carrier shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 509 and 514C and 1999 Iowa Acts, Senate File 276.

191—35.35(509) Reconstructive surgery.

35.35(1) A carrier or organized delivery system that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

35.35(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

35.35(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

35.35(4) A carrier or organized delivery system shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier or organized delivery system shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

CONSUMER GUIDE

191—35.36(514K) Purpose. These rules implement Iowa Code Supplement section 514K.1(2) which requires the commissioner and the director of public health to annually publish a consumer guide. These rules apply to all carriers providing health insurance coverage in the individual, small employer group and large group markets that utilize a preferred provider arrangement and to all health maintenance organizations.

191—35.37(514K) Information filing requirements.

35.37(1) Each health maintenance organization shall annually file with the division no later than July 1 the following information by plan as requested by the division:

a. Health plan employer data information set (HEDIS).

b. Network composition.

c. Other information determined to be beneficial to consumers including but not limited to consumer survey information.

35.37(2) Each preferred provider organization health network shall annually file with the division no later than July 1 the following information by plan as requested by the division:

a. Reportable information as defined by a nationally recognized accreditation organization for preferred provider organization health networks.

b. Network composition.

c. Other information determined to be beneficial to consumers including but not limited to consumer survey information.

35.37(3) Each health maintenance organization and insurer using a preferred provider organization health network shall transmit the requested information by electronic mail or diskette in a format prescribed by the division.

191—35.38(514K) Limitation of information published. The division may establish limits on the data to be collected and published in the event the division believes the information is not statistically relevant and would not be beneficial to consumers.

These rules are intended to implement Iowa Code Supplement section 514K.1(2).

191—35.39(514C) Contraceptive coverage.

35.39(1) A carrier or organized delivery system that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

35.39(2) A carrier or organized delivery system is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

35.39(3) A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

35.39(4) A carrier or organized delivery system shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

35.39(5) If a carrier or organized delivery system does not provide benefits for a routine physical examination, the carrier or organized delivery system is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement 2000 Iowa Acts, Senate File 2126.

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[1] See IAB Insurance Division

CHAPTER 36
INDIVIDUAL
ACCIDENT AND HEALTH—MINIMUM STANDARDS

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

191—36.1(514D) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514D so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations which may be misleading or confusing in connection either with the purchase of the coverages or with the settlement of claims and to provide for full disclosure in the sale of the coverages.

191—36.2(514D) Applicability and scope. This chapter shall apply to all individual accident and sickness insurance policies and subscriber contracts of service corporations, organized under Iowa Code chapter 514, delivered or issued for delivery to any person in this state on and after the effective date hereof, except it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this chapter. The requirements contained in this chapter shall be in addition to any other applicable regulations previously adopted.

191—36.3(514D) Effective date. This chapter shall be effective on December 31, 1981, and shall be applicable to all new filings of individual accident and sickness insurance policies and nonprofit hospital, medical and dental service contracts made after that date, and all other policies and contracts covered by this chapter and delivered or issued for delivery after June 30, 1982, shall be in compliance with this chapter.

191—36.4(514D) Policy definitions. Except as provided hereafter, no individual accident or sickness insurance policy or hospital, medical, or dental service corporation subscriber contract delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this rule.

36.4(1) *"One period of confinement"* means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

36.4(2) *"Hospital"* may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

a. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(1) Be an institution operated pursuant to law; and

(2) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

(3) Provide 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

b. The definition of the term "hospital" may state that the term shall not be inclusive of:

(1) Convalescent homes, convalescent, rest, or nursing facilities; or

(2) Facilities primarily affording custodial, educational or rehabilitative care; or

(3) Facilities for the aged, drug addicts or alcoholics; or

(4) Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except where a legal liability exists for charges made to the individual.

36.4(3) *"Nursing facility"* shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law;

(2) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(3) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(4) Provide continuous 24-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(5) Maintains a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not be inclusive of:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

36.4(4) *"Skilled nursing care"* and *"convalescent nursing care,"* when used in a policy, shall be defined in the policy as follows: Skilled nursing care or convalescent nursing services means any treatment which is rehabilitative in nature, which is required to restore an individual to the individual's prior level of health after an accident or illness and hospitalization, and which is related to the condition which was the cause of the confinement. Skilled nursing care and convalescent nursing care are any level of care greater than custodial care.

36.4(5) *"Custodial nursing care"* shall be defined as that level of nursing care required to assist an individual in meeting day-to-day living requirements, such as but not limited to, eating, bathing, dressing, and which care is required primarily due to reasons of age and not reasons of sickness.

36.4(6) *"Accident"* and *"accidental injury"* shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause, and occur while the insurance is in force.

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

36.4(7) *"Sickness"* shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

36.4(8) *"Preexisting condition"* shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment within a five-year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five-year period preceding the effective date of the insured person.

36.4(9) *"Physician"* may be defined by including words such as *"duly qualified physician"* or *"duly licensed physician."* The use of the term "physician" requires an insurer to recognize and to accept, to the

extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

36.4(10) *"Nurses"* may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific definition, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Iowa.

36.4(11) *"Total disability".*

a. A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience and who is not in fact engaged in any employment or occupation for wage or profit.

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (1) perform "any occupation whatsoever," "any occupational duty," or "any and every duty of the person's occupation"; or (2) engage in any training or rehabilitation program.

c. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of the person's regular occupation or use words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

36.4(12) *"Partial disability"* shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

36.4(13) *"Residual disability"* shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or another term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

36.4(14) *"Medicare"* shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act," "as then constituted and any later amendments or substitutes thereof," or words of similar import.

36.4(15) *"Complications of pregnancy"* shall be defined to include:

a. Conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy; and

b. Nonelective Caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

36.4(16) *"Mental or nervous disorders"* shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

This rule is intended to implement Iowa Code section 514D.3.

191—36.5(514D) Prohibited policy provisions.

36.5(1) Except as provided in subrule 36.4(7), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix, and tonsils. However, the permissible six months' exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

36.5(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional with the policyholder.

36.5(3) No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and preexisting condition is not specifically excluded by the terms of the policy.

36.5(4) A disability income policy may contain a "return of premium" or "cash value benefit" so long as:

a. Such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

b. The insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

36.5(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

36.5(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

b. Mental or emotional disorders, alcoholism and drug addiction;

c. Pregnancy, except for complications of pregnancy;

d. Illness or medical condition arising out of:

(1) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; or service in the armed forces or units auxiliary thereto;

(2) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(3) Aviation;

(4) With respect to short-term nonrenewable policies, of less than 12 months in duration, interscholastic sports;

(5) With respect to disability income protection policies, incarceration;

e. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

h. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

i. Dental care or treatment;

j. Eye glasses, hearing aids and examination for the prescription or fitting thereof;

k. Rest cures, custodial care, transportation and routine physical examinations;

l. Territorial limitations.

36.5(7) The provisions of this chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

36.5(8) Except as otherwise provided in 36.7(1), the terms "Medicare supplement," "Medigap," and words of similar import shall not be used unless the policy is issued in compliance with 191—Chapter 37.

36.5(9) Policy provisions precluded in this subrule shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions or coverages in accordance with Iowa Code section 514D.3(2), which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

36.5(10) Rescinded IAB 10/30/91, effective 12/4/91.

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

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

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

36.6(1) *General rules.*

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

b. The terms "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 36.7(1)*"a."* The terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided, however, any accident and health or accident only policy which provides

for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60 the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

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

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

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

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

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

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

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

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

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

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

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

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

o. Rescinded IAB 11/27/91, effective 1/1/92.

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

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

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

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

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

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

a. Surgical services:

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

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

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

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

(2) Fifteen percent of the surgical service benefit.

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

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

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

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

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

a. "Individual major medical expense coverage" is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $500,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered

charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed $10,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 5 percent of the aggregate maximum limit under the policy for each covered person for at least:

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

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

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

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

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

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

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

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

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

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

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

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

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

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

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

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

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

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

b. Contains an elimination period no greater than:

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

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

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

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

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

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

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

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

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

(1) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount, if any, not in excess of $250 and an overall

aggregate benefit limit of not less than $5,000 and a benefit period of not less than two years for at least the following incurred expenses:

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

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

b. "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $5,000 for accidental death, $5,000 for double dismemberment, and $2,500 for single dismemberment.

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

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

191—36.7(514D) Required disclosure provisions.

36.7(1) *General rules.*

a. Each individual policy of accident and sickness insurance or hospital, medical, or dental service corporation subscriber contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

b. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

c. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

d. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition and

explanation of the terms "usual and customary" or "reasonable and customary" in its accompanying outline of coverage.

e. If a policy contains any limitations with respect to preexisting conditions the limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

f. All accident only policies shall contain a prominent statement on the first page of the policy or attached to it, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, as follows:

"This is an accident only policy and it does not pay benefits for loss from sickness."

g. All policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached to it stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

h. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

i. If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

j. Insurers issuing policies which provide hospital or medical expense coverage on an expense-incurred or indemnity basis other than incidentally, to a person(s) eligible for Medicare by reason of age, shall provide to the policyholder a Medicare supplement buyer's guide in the form of the booklet "Guide to Health Insurance for People with Medicare" developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services. Delivery of the buyer's guide shall be made whether or not the policy qualifies as a "Medicare supplement coverage" in accordance with 191—Chapter 37. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application and acknowledgment of receipt of certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon request but not later than at the time the policy is delivered.

k. Outlines of coverage delivered in connection with policies defined in this chapter as Hospital Confinement Indemnity, Specified Disease or Limited Benefit Health Insurance Coverages to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of 36.7(6), 36.7(10) and 36.7(12), the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Medicare Supplement Buyer's Guide, available from the company.

l. If payment will not be made for services performed by a chiropractor acting within the scope of the chiropractor's license when those services would be compensable if performed by a medical doctor, then a statement that services performed by a chiropractor are not compensable shall be included in all outlines of coverage delivered in accordance with this chapter.

m. Disclosure requirements. All insurers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all insurers offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All insurers shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical

purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

36.7(2) *Outline of coverage requirements for individual coverages.* No individual accident and sickness insurance policy or nonprofit hospital, medical or dental service corporation subscriber contract subject to this chapter shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in 36.7(3) to 36.7(12), is completed as to the policy or contract and

a. Delivered with the policy; or

b. Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of the outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of 36.6(2) shall be that statement contained in 36.7(3). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(3) shall be the statement contained in 36.7(5). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(5) or 36.6(3) and 36.6(5) or 36.6(2), 36.6(3), and 36.6(5) shall be the statement contained in 36.7(7).

Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical, or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

36.7(3) *Basic hospital expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2). The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Basic hospital expense coverage. Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy in the following order:

(1) Daily hospital room and board;

(2) Miscellaneous hospital services;

(3) Hospital outpatient services; and

(4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(4) *Basic medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of subrule 36.6(3). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Basic medical-surgical expense coverage. Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(1) Surgical services;
(2) Anesthesia services;
(3) In-hospital medical services; and
(4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(5) *Basic hospital and medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2) and 36.6(3) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Basic hospital and medical-surgical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(1) Daily hospital room and board;
(2) Miscellaneous hospital services;
(3) Hospital outpatient services;
(4) Surgical services;

(5) Anesthesia services;

(6) In-hospital medical services; and

(7) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(6) *Hospital confinement indemnity coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(4). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Hospital confinement indemnity coverage. Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. These policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

c. (A brief specific description of the benefits contained in this policy, in the following order:

(1) Daily benefit payable during hospital confinement; and

(2) Duration of benefit described in *"c"*(1).)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

f. (Any benefits provided in addition to the daily hospital benefit.)

36.7(7) *Major medical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(5) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Major medical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(1) Daily hospital room and board;

(2) Miscellaneous hospital services;
(3) Surgical services;
(4) Anesthesia services;
(5) In-hospital medical services;
(6) Out-of-hospital care;
(7) Maximum dollar amount for covered charges; and
(8) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(8) *Disability income protection coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(6) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Disability income protection coverage. Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(9) *Accident only coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(7). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Accident only coverage. Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1)*"m."*)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(10) *Specified disease or specified accident coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(8). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. (Specified disease) (Specified accident) coverage. Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1)*"m."*)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in *"c"* above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation or right to change premiums.)

36.7(11) *Medicare supplement coverage (outline of coverage).* Rescinded IAB 10/30/91, effective 12/4/91.

36.7(12) *Limited benefit health coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of subrules 36.6(2) to 36.6(8). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Limited benefit health coverage. Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subrule 36.6(1)*"n."*)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 36.7(12) *"c."*)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

191—36.8(507B) Requirements for replacement.

36.8(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

36.8(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in 36.8(3). One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in 36.8(4). In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

36.8(3) The notice required by 36.8(2) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

36.8(4) The notice required by subrule 36.8(2) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for

benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

c. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

191—36.9(514D) Filing requirements.

36.9(1) *Rate filing.* Every policy, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in a rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement shall also be filed.

36.9(2) *Contents of rate filings.* Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated creditable loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of these present values only if it is a significant factor in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of Iowa and that the benefits are reasonable in relation to premiums.

36.9(3) *Previously approved forms.* Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

a. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form.

b. A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefor.

c. A history of the experience under existing rates, including at least the data indicated in 36.9(4). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim runoffs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.

d. The date and magnitude of each previous rate change, if any.

36.9(4) *Experience records.* Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the accident and health policy experience exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar

year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

36.9(5) *Evaluating experience data.* In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

a. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.

b. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.

c. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.

d. The mix of business by risk classification.

191—36.10(514D) Loss ratios.

36.10(1) *Average annual premium.*

a. New forms. With respect to a new form under which the average annual premium (as defined below) is expected to be at least $200 benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of	Renewal Clause			
Coverage	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and other	60%	55%	50%	45%

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is $100 or more but less than $200, subtract five percentage points from the numbers in the table above, or if less than $100, subtract ten percentage points.

b. The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The above anticipated loss ratio standards do not apply to a class of business where such standards are in conflict with specific statutes or regulations.

c. Definitions of renewal clause.

OR—Optionally Renewable: Renewal is at the option of the insurance company.

CR—Conditionally Renewable: Renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR—Guaranteed Renewable: Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC—Non-Cancelable: Renewal cannot be declined nor can rates be revised by the insurance company.

36.10(2) *Rate revisions.* With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided the following standards are met.

a. With respect to forms issued on and after the effective date of the revision, the standards are the same as in 36.10(1) above, except that the average annual premium shall be determined based on an actual rather than an anticipated distribution of business.

b. With respect to forms issued prior to the effective date of the revision, both (1) and (2) as follows shall be at least as great as the standards in 36.10(1):

(1) The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

(2) The ratio of (i) and (ii); where

(i) Is the sum of the accumulated benefits, from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision, and the present value of future benefits, and

(ii) Is the sum of the accumulated premiums from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

36.10(3) *Credibility factors.* Anticipated loss ratios different than those indicated in 36.10(1) and 36.10(2) will require justification based on the special circumstances that may be applicable.

a. Examples of coverages requiring special consideration are as follows:

(1) Accident only;

(2) Short term nonrenewable, e.g., airline trip, student accident;

(3) Specified peril, e.g., cancer, common carrier;

(4) Other special risks.

b. Examples of other factors requiring special consideration are as follows:

(1) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;

(2) Extraordinary expenses;

(3) High risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;

(4) Product features such as long elimination periods, high deductibles and high maximum limits;

(5) The industrial or debit method of distribution;

(6) Forms issued prior to the effective date of these guidelines.

Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

36.10(4) *Medicare supplement policies.* Rescinded IAB 10/30/91, effective 12/4/91.

191—36.11(514D) Certification. Any policy form submitted to the insurance division for approval which is subject to Iowa Code chapter 514D shall be in conformance with the applicable requirements of Iowa Code chapter 514D and with the filing requirements set forth in rule 191—20.1(505,509,514A,515,515A,515F).

191—36.12(514D) Severability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code chapters 507B, 510 and 514D.

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[2] See IAB Insurance Division

CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE

DIVISION I
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

191—37.1(514D) Purpose. The purpose of this chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

191—37.2(514D) Applicability and scope.

37.2(1) Except as otherwise specifically provided in rules 191—37.6(514D), 191—37.13(514D), 191—37.14(514D), 191—37.17(514D) and 191—37.21(514D), this chapter shall apply to:

a. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

b. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

37.2(2) This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.3(514D) Definitions. For purposes of this chapter:

"1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan" or *"1990 plan"* means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010, which are not replaced by the issuer at the request of the insured.

"2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan" or *"2010 plan"* means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

"Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
2. In the case of a group Medicare supplement policy, the proposed certificate holder.

"Bankruptcy" means a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

5. Chapter 55 of Title 10, United States Code (CHAMPUS);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

11. A organized delivery system.

12. Short-term limited durational policy.

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means that an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended."

"Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C (as defined in 42 U.S.C. 1395w-28(b)(1)), and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

"Medicare supplement policy" " means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Prestandardized Medicare supplement benefit plan" or *"prestandardized plan"* means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.4(514D) Policy definitions and terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this rule.

"Accident," "accidental injury," or *"accidental means"* shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

"Benefit period" or *"Medicare benefit period"* shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent nursing home," "extended care facility," or *"skilled nursing facility"* shall not be defined more restrictively than as defined in the Medicare program.

"Health care expenses" means, for purposes of rule 191—37.14(514D), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

"Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Pub. L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

"Physician" shall not be defined more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

191—37.5(514D) Policy provisions.

37.5(1) Except for permitted preexisting condition clauses as described in 37.6(1)*"a,"* 37.7(1)*"a,"* and 37.8(1)*"a,"* no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

37.5(2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

37.5(3) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

37.5(4) Subject to paragraphs 37.6(1)*"d," "e,"* and *"g"* and 37.7(1)*"d"* and *"e,"* a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

37.5(5) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

37.5(6) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

a. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan; and

b. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

37.6(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. (1) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph *"e"*(4) below, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 37.7(2).

(3) If membership in a group is terminated, the issuer shall:

1. Offer the certificate holder such conversion opportunities as are described in 37.6(1)*"e"*(2); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

37.6(2) *Minimum benefit standards.*

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100);

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

37.7(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under 37.7(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

1. Provides for continuation of the benefits contained in the group policy, or
2. Provides for such benefits as otherwise meets the requirements of this subrule.

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in 37.7(1)*"e"*(3), or
2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. (1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstitution of such coverages:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

h. If an issuer makes a written offer to an insured who holds one or more of the issuer's 1990 Standardized Medicare supplement policies or certificates (as described in rule 191—37.9(514D)) to allow the insured to exchange that policy during a specified period of time for a 2010 standardized plan (as described in rule 191—37.10(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner if the insured exchanges a 1990 standardized policy or certificate for an issue-age-rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's 1990 standardized policy or certificate to be exchanged is priced on an issue-age rate schedule at the time of such offer, the rate charged to the insured for the new 2010 exchanged standardized policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.15(514D).

(2) The rating class of the new 2010 standardized policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new 2010 standardized policy or certificate for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged 1990 standardized policy or certificate.

(4) The new 2010 standardized policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

37.7(2) *Standards for Basic ("Core") Benefits Common to A-J Benefit Plans.* Every issuer shall make available a policy or certificate including only the following basic "Core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "Core" package, but not in lieu thereof.

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

37.7(3) *Standards for Additional Benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by 191—37.9(514D).

a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures.

(2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-Home Recovery Benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

2. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

3. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

4. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.
- The actual charges for each visit up to a maximum reimbursement of $40 per visit.
- One thousand six hundred dollars per calendar year.
- Seven visits in any one week.
- Care furnished on a visiting basis in the insured's home.
- Services provided by a care provider as defined in this paragraph *"j."*
- At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

k. Rescinded IAB 1/5/05, effective 2/9/05.

37.7(4) *Standards for Plan "K."* Standardized Medicare supplement benefit plan "K" shall consist of the following:

a. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

b. Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment in full and may not bill the insured for any balances;

d. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph *"j"*;

e. Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in paragraph *"j"*;

f. Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph *"j"*;

g. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph *"j"*;

h. Except for coverage provided in paragraph *"i,"* coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph *"j"*;

i. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

j. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

37.7(5) *Standards for Plan "L."* Standardized Medicare supplement benefit plan "L" shall consist of the following:

a. The benefits described in paragraphs 37.7(4)*"a," "b," "c,"* and *"i"*;

b. The benefits described in paragraphs 37.7(4)*"d," "e," "f," "g,"* and *"h"* but substituting 75 percent for 50 percent; and

c. The benefits described in paragraph 37.7(4)*"j"* but substituting $2,000 for $4,000.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. Insurers may begin submitting policies and certificates to the division for approval on or after January 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of rule 191—37.7(514D).

37.8(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

1. Provides for continuation of the benefits contained in the group policy; or

2. Provides for benefits that otherwise meet the requirements of paragraph 37.8(1)*"e."*

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in subparagraph 37.8(1)*"e"*(3); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the group policy that is being replaced on that policy's date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. Suspension of benefits.

(1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(4) Reinstitution of coverage as described in subparagraphs 37.8(1)*"g"*(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

37.8(2) *Standards for basic (core) benefits common to Medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N.* Every issuer of Medicare supplement insurance benefit plans shall make available to each prospective insured a policy or certificate including only the following basic (core) package of benefits. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core package must provide:

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

f. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

37.8(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by rule 191—37.10(514D):

a. Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

b. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

c. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

d. Medicare Part B Deductible: Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

e. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

f. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.9(514D) Standard Medicare supplement benefit plans for 1990 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage prior to June 1, 2010.

37.9(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "Core" benefits as defined in 37.7(2).

37.9(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in 37.9(7) and in 191—37.11(514D).

37.9(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this rule and conform to the definitions in 191—37.3(514D). Each benefit shall be structured in accordance with the format provided in 37.7(2), 37.7(3), 37.7(4) and 37.7(5) and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.9(4) An issuer may use, in addition to the benefit plan designations required in 37.8(3), other designations to the extent permitted by law.

37.9(5) Makeup of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 37.7(2).

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible as defined in 37.7(3)*"a."*

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c,"* and *"h,"* respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "h,"* and *"j,"* respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in 37.7(3)*"a," "b," "h,"* and *"i,"* respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c," "e,"* and *"h,"* respectively.

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a

Foreign Country, and the At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "d," "h,"* and *"j,"* respectively.

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "f,"* and *"h,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "e," "f," "h,"* and *"j,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

k. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible Skilled Nursing Facility Care, the Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c," "e,"* and *"h,"* respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist only of the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the Core Benefit as defined in 37.7(2), plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100 percent of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

37.9(6) Standardized Medicare supplement benefit plan "K" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(4). Standardized Medicare supplement benefit plan "L" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(5).

37.9(7) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2004, the innovative benefit shall not include an outpatient prescription drug benefit.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.10(514D) Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of rules 191—37.6(514D) and 191—37.9(514D).

37.10(1) Issuer to make form available.

a. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subrule 37.8(2).

b. If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.10(5)*"h"* and *"i"*), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph 37.10(1)*"a,"* a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph 37.10(5)*"c"*) or standardized benefit Plan F (as described in paragraph 37.10(5)*"e"*).

37.10(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.10(6) and rule 191—37.11(514D).

37.10(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in rule 191—37.10(514D) and conform to the definitions in rule 191—37.3(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2) and 37.8(3), or, in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraphs 37.10(5)*"h"* and *"i."* Each plan shall list the benefits in the order shown. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.10(4) In addition to the benefit plan designations required in subrule 37.10(3), an issuer may use other designations to the extent permitted by law.

37.10(5) Makeup of 2010 standardized benefit plans.

a. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subrule 37.8(2).

b. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3)*"a."*

c. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d,"* and *"f,"* respectively.

d. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible,

skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively.

e. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

f. Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.10(5)*"f"*(2).

(1) The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

g. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "e,"* and *"f,"* respectively.

h. Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance from the sixty-first through ninetieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(2) Part A hospital coinsurance from the ninety-first through one hundred fiftieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(3) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(5) Skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(6) Hospice care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(7) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(8) Part B cost sharing: Except for coverage provided in subparagraph 37.10(5)*"h"*(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificate holder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(9) Part B preventive services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder or certificate holder pays the Part B deductible; and

(10) Cost sharing after out-of-pocket limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in subparagraphs 37.10(5)*"h"*(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.10(5)*"h"*(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.10(5)*"h"*(10), but substituting $2000 for $4000.

j. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, 100 percent of skilled nursing facility care, and 100 percent of medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"b," "c,"* and *"f,"* respectively.

k. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively, with copayments in the following amounts:

(1) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(2) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

37.10(6) New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. The commissioner shall use any guidelines issued by the National Association of Insurance Commissioners in determining whether to approve new or innovative benefits.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.11(514D) Medicare Select policies and certificates.

37.11(1) *a.* Rule 191—37.11(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

b. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

37.11(2) For the purposes of this rule:

a. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

b. *"Grievance"* means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

c. *"Medicare Select Issuer"* means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

d. *"Medicare Select Policy"* or *"Medicare Select Certificate"* means respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

e. *"Network Provider"* means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

f. *"Restricted Network Provision"* means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

g. *"Service Area"* means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

37.11(3) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements.

37.11(4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

37.11(5) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(1) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

1. To adequately deliver all services that are subject to a restricted network provision; or
2. To make appropriate referrals.

(3) There are written agreements with network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

(5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with 37.11(9).

g. Any other information requested by the commissioner.

37.11(6) *a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing

such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

b. An updated list of network providers shall be filed with the commissioner at least quarterly.

37.11(7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

b. It is not reasonable to obtain such services through a network provider.

37.11(8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

37.11(9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(1) Other Medicare supplement policies or certificates offered by the issuer; and

(2) Other Medicare Select policies or certificates.

b. A description (including address, telephone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L."

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

37.11(10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to 37.11(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

37.11(11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action shall be taken promptly.

e. All concerned parties shall be notified about the results of a grievance.

f. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

37.11(12) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

37.11(13) *a.* At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

37.11(14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

37.11(15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.12(514D) Open enrollment.

37.12(1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subrule without regard to age.

37.12(2) If an applicant under subrule 37.12(1) submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

If the applicant qualifies under subrule 37.12(1) and submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subrule.

37.12(3) Except as provided in 191—37.22(514D) or 191—37.25(514D), subrule 37.12(1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based

on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.13(514D) Standards for claims payment.

37.13(1) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

37.13(2) Compliance with the requirements set forth in 37.13(1) shall be certified on the Medicare supplement insurance experience reporting form.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.14(514D) Loss ratio standards and refund or credit of premium.

37.14(1) *Loss ratio standards.*

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(1) At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or

(2) At least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

b. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. For all policies issued prior to January 1, 1992, expected claims in relation to premiums shall meet:

(1) The originally filed anticipated loss ratio when combined with the actual experience from inception;

(2) The appropriate loss ratio requirement from 37.14(1)*"a"*(1) and (2) when combined with actual experience beginning with January 1, 1996, to date; and

(3) The appropriate loss ratio requirement from 37.14(1)*"a"*(1) and (2) over the entire future period for which rates are computed to provide coverage.

37.14(2) *Refund or credit calculation.*

a. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

b. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

c. For purposes of this subrule, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first report shall be due May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

37.14(3) *Annual filing of premium rates.* An issuer of Medicare supplement policies and certificates issued before or after the effective date of January 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

a. (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule.

b. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

37.14(4) *Public hearings.* The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of January 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.15(514D) Filing and approval of policies and certificates and premium rates.

37.15(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed pursuant to rule 191—20.1(505,509,514A,515,515A,515F) and approved by the commissioner.

37.15(2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

37.15(3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

37.15(4) *a.* Except as provided in paragraph *"b"* of this subrule, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

b. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(1) The inclusion of new or innovative benefits;

(2) The addition of either direct response or agent marketing methods;

(3) The addition of either guaranteed issue or underwritten coverage;

(4) The offering of coverage to individuals eligible for Medicare by reason of disability.

c. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

37.15(5) *a.* Except as provided in subparagraph *"a"*(1) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after January 1, 1992, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph *"a"*(1) above shall not file for approval of a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subrule.

c. A change in the rating structure or methodology shall be considered a discontinuance under paragraph *"a"* of this subrule unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

37.15(6) *a.* Except as provided in paragraph *"b"* of this subrule, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 191—37.14(514D).

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.16(514D) Permitted compensation arrangements.

37.16(1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate i n the second year or period.

37.16(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

37.16(3) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

37.16(4) For purposes of this rule, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.17(514D) Required disclosure provisions.

37.17(1) *General rules.*

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provisions shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. (1) Issuers of accident and sickness policies, or certificates which provide hospital or medical expense coverage on an expense-incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(2) For the purposes of this rule, "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

37.17(2) *Notice requirements.*

a. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner.

(1) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices shall not contain or be accompanied by any solicitation.

37.17(3) *MMA notice requirements.* Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

37.17(4) *Outline of coverage requirements for Medicare supplement policies.*

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this subrule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed.

The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

d. The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance*		Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[2070]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[1860] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [The last sentence of this paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[Insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subrule. An issuer may use additional benefit plan descriptions on these charts pursuant to subrule 37.10(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$0	$[992] (Part A deductible)
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	$0	Up to $[124] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN B
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	$0	Up to $[124] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN C
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN D
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

***Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

***Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[496] (50% of Part A deductible)	$[496] (50% of Part A deductible)♦
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[62] a day	Up to $[62] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare-Covered Services	Generally 75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[4140])*****
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[744] (75% of Part A deductible)	$[248] (25% of Part A deductible)♦
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[93] a day	Up to $[31] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance♦

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare-Covered Services	Generally 75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[2070])*****
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2070] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[496] (50% of Part A deductible)	$[496] (50% of Part A deductible)
61st through 90th day	All but $[248] a day	$[496] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	0%
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN N
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

37.17(5) *Notice regarding policies or certificates which are not Medicare supplement policies.*

a. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy, or other policy identified in 191—37.2(514D) issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in 37.17(4)*"a"* shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.18(514D) Requirements for application forms and replacement coverage.

37.18(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

a. Statements.

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your

policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

b. Questions.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X".)

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

Yes____No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____No____

(c) Was this your first time in this type of Medicare plan?

Yes____No____

(d) Did you drop a Medicare supplement policy to enroll in this plan?

Yes____No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]? _____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

37.18(2) Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

37.18(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

37.18(4) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

37.18(5) The notice required by subrule 37.18(4) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement

coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. [optional only for Direct Mailers]
____ Other. (Please specify.)_____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

37.18(6) Statements 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.19(514D) Standards for marketing.

37.19(1) An issuer, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies by its agent or other producers will be fair and accurate.

b. Establish marketing procedures to ensure excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy, the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

e. Establish auditable procedures for certifying compliance with this subrule.

f. At solicitation, provide written notice to the prospective policyholder or certificate holder of the name, address, and telephone number of the senior insurance counseling program approved in Iowa by the commissioner of insurance. The written notice shall be in a form prescribed by the commissioner.

37.19(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. High-pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold-lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

37.19(3) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this chapter.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.20(514D) Appropriateness of recommended purchase and excessive insurance.

37.20(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

37.20(2) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

37.20(3) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.21(514D) Reporting of multiple policies.

37.21(1) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

a. Policy and certificate number, and

b. Date of issuance.

37.21(2) The items set forth above must be grouped by individual policyholder.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.22(514D) Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.

37.22(1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

37.22(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any

time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.23(514D) Prohibition against use of genetic information and requests for genetic testing. This rule applies to all policies with policy years beginning on or after May 21, 2009.

37.23(1) For the purposes of this rule only, the following definitions shall apply:

"Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

"Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. "Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

"Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

"Issuer of a Medicare supplement policy or certificate" means the same as "issuer" as defined in rule 191—37.3(514D) and includes third-party administrator, or other person acting for or on behalf of such issuer.

"Underwriting purposes" means:

1. Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the policy;
2. The computation of premium or contribution amounts under the policy;
3. The application of any preexisting condition exclusion under the policy; and
4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

37.23(2) An issuer of a Medicare supplement policy or certificate:

a. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) of an individual on the basis of the genetic information with respect to such individual; and

b. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

37.23(3) Nothing in subrule 37.23(2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of another individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

37.23(4) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

37.23(5) Subrule 37.23(4) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subrule 37.23(2).

37.23(6) For purposes of carrying out subrule 37.23(5), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

37.23(7) Notwithstanding subrule 37.23(4), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

a. The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

c. No genetic information collected or acquired under this subrule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

d. The issuer notifies the Secretary of the U.S. Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subrule, including a description of the activities conducted.

e. The issuer complies with such other conditions as the Secretary of the U.S. Department of Health and Human Services may by regulation require for activities conducted under this subrule.

37.23(8) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

37.23(9) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

37.23(10) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subrule 37.23(9) if such request, requirement, or purchase is not in violation of subrule 37.23(8).

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.24(514D) Prohibition against using SHIIP prepared materials The Senior Health Insurance Information Program (SHIIP) may prepare a consumer Medicare supplement insurance premium guide and benefits comparison guide. This guide and the SHIIP name or logo shall not be used in the solicitation or sale of health insurance products. Violation of this provision shall be deemed an unfair trade practice under Iowa Code chapter 507B.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.25(514D) Guaranteed issue for eligible persons.

37.25(1) Eligible persons are those individuals described in subrule 37.25(2) who seek to enroll under the policy during the period specified in subrule 37.25(3) and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subrule 37.25(5) that is offered and is available for issuance to

new enrollees by issuer, shall not discriminate in the pricing of such Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such Medicare supplement policy.

37.25(2) An eligible person is an individual described in any of the following paragraphs:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental health benefits to the individual;

b. The individual is enrolled with a Medicare Advantage organization under Medicare Advantage under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act and circumstances exist similar to those described below that would permit discontinuance of the individual's enrollment with such a provider if such individual were enrolled in Medicare Advantage:

(1) The certification of the organization or plan under this part has been terminated; or

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; or

(4) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the Secretary may provide;

c. The individual is enrolled with:

(1) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or

(3) An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(4) An organization under Medicare Select policy; and

(5) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 37.25(2)*"b"*;

d. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

e. The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under Medicare Advantage under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment under 37.25(2)*"e"* was terminated by the enrollee during any period

within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

f. The individual upon first becoming enrolled for benefits under Part B of Medicare at age 65 or older enrolls in Medicare Advantage under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act and disenrolls from the plan or program by no later than 12 months after the effective date of enrollment.

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph 37.25(5)*"e."*

37.25(3) Guaranteed issue time periods.

a. In the case of an individual described in paragraph 37.25(2)*"a,"* the guaranteed issue period begins on the later of: (1) the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (2) the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

b. In the case of an individual described in paragraph 37.25(2)*"b," "c," "e"* or *"f"* whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

c. In the case of an individual described in subparagraph 37.25(2)*"d"*(1), the guaranteed issue period begins on the earlier of (1) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (2) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

d. In the case of an individual described in paragraph 37.25(2)*"b,"* subparagraph 37.25(2)*"d"*(2), subparagraph 37.25(2)*"e"*(2), paragraph 37.25(2)*"e"* or paragraph 37.25(2)*"f"* who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

e. In the case of an individual described in paragraph 37.25(2)*"g,"* the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

f. In the case of an individual described in subrule 37.25(2) but not described in the preceding paragraphs 37.25(3)*"a"* to *"e,"* the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

37.25(4) Extended Medigap access for interrupted trial periods.

a. In the case of an individual described in paragraph 37.25(2)*"e"* (or deemed to be so described pursuant to paragraph 37.25(4)*"a"*) whose enrollment with an organization or provider described in paragraph 37.25(2)*"e"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2)*"e."*

b. In the case of an individual described in paragraph 37.25(2)*"f"* (or deemed to be so described pursuant to paragraph 37.25(4)*"b"*) whose enrollment with a plan or in a program described in paragraph 37.25(2)*"f"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2)*"f."*

c. For purposes of paragraphs 37.25(2)*"e"* and *"f,"* no enrollment of an individual with an organization or provider described in paragraph 37.25(2)*"e,"* or with a plan or in a program described in paragraph 37.25(2)*"f,"* may be deemed to be an initial enrollment under paragraph 37.25(4)*"c"*

after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

37.25(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

a. Subrule 37.25(2), paragraphs *"a," "b," "c,"* and *"d,"* is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

b. Subject to paragraph 37.25(5)*"c,"* paragraph 37.25(2)*"e"* is the same Medicare supplement policy in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.25(5)*"a."*

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

d. Paragraph 37.25(2)*"f"* shall include any Medicare supplement policy offered by any issuer.

e. Paragraph 37.25(2)*"g"* is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

37.25(6) Notification of provisions.

a. At the time of an event described in subrule 37.25(2) because of which an individual loses coverage or benefits due to the termination or change of a contract or agreement, policy, or plan, the organization that terminates or changes the contract or agreement, the issuer terminating or changing the policy, or the administrator of the plan being terminated or changed, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subrule 37.25(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated within ten working days of the issuer receiving notification of the disenrollment.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.26(514D) Severability. If any provisions of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.27 to **37.49** Reserved.

DIVISION II
MEDICARE SUPPLEMENT ADVERTISING

191—37.50(507B,514D) Purpose. The purpose of the rules in this division is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance and to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising

of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and which is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.51(507B,514D) Applicability.

37.51(1) "Insurer," for the purpose of these rules, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an "issuer" in rule 191—37.3(514D) and is engaged in the advertisement of itself, or Medicare supplement insurance.

These rules shall apply to any "advertisement" of Medicare supplement insurance, as that term is defined in rule 191—37.52(507B,514D), unless otherwise specified in Division II of this chapter, that the insurer or producer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer, as those terms are defined in rule 191—15.2(507B).

37.51(2) Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

37.51(3) The requirements of Iowa Code chapter 507B and 191—Chapter 15 also shall apply to insurers and producers to which 191—Chapter 37, Division II, applies, unless specifically exempted therein.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.52(507B,514D) Definitions. In addition to the definitions in Iowa Code section 507B.2 and rule 191—15.2(507B), the following definitions shall apply to 191—Chapter 37, Division II. When there is a definition for a term in this rule and also in Iowa Code section 507B.2 or rule 191—15.2(507B), the definition in this rule shall take precedence.

"Advertisement" includes:

1. The definition of "advertisement" in rule 191—15.2(507B).
2. Advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.
3. The definition of "advertisement" does not include:

- Items excluded in the definition of "advertisement" in rule 191—15.2(507B).
- Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract.
- Court-approved material ordered by a court to be disseminated to policyholders.

"Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

"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 Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

"Lead-generating device" means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

"Limitation" means any provision other than an exception or a reduction that restricts coverage under the policy.

"Medicare" means "The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and also known as the "Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare supplement insurance" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

"Person" means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

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

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.53(507B,514D) Form and content of advertisements. An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.54(507B,514D) Testimonials or endorsements by third parties. In addition to complying with 191—subrule 15.3(7), when a testimonial refers to benefits received under a Medicare supplement insurance policy, the insurer shall retain the specific claim data, including claim number, date of loss, and other pertinent information, for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.55(507B,514D) Use of statistics; jurisdictional licensing; status of insurer. Advertisements shall be in compliance with 191—subrule 15.3(5) and with the following:

37.55(1) An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, the advertisement shall state clearly that the data do not relate to the policy being advertised.

37.55(2) An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

37.55(3) An advertisement shall not create the impression directly or indirectly that the insurer, the insurer's financial condition or status, the insurer's payment of its claims, or the merits, desirability or advisability of the insurer's policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or of the United States government.

37.55(4) An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of this state or of the United States government. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, its advertising or its financial condition.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.56(507B,514D) Identity of insurer. Advertisements shall be in compliance with 191—subrule 15.3(9) and with the following:

37.56(1) Advertisements, stationery or envelopes that employ words, letters, initials, symbols or other devices are not permitted if they are so similar to those used by governmental agencies or other insurers that they may lead the public to believe:

a. The advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

b. The advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

37.56(2) No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

37.56(3) No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

37.56(4) No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating the plan or policy from Medicare. Such an advertisement, however, shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

37.56(5) No advertisement shall be used that fails to include a disclaimer to the effect of "Not connected with or endorsed by the U.S. government or the federal Medicare program."

37.56(6) No advertisement may imply that the reader may lose a right, privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

37.56(7) No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

37.56(8) All advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before the advertisements may be used.

37.56(9) A producer who makes contact with a consumer as a result of acquiring that consumer's name from a lead-generating device shall disclose that fact in the initial contact with the consumer.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.57(507B,514D) Introductory, initial or special offers.

37.57(1) Enrollment periods.

a. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such representation is true. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

b. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not fewer than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, electronic mail, Web sites, radio, television, magazines and periodicals, used by any one insurer. This rule is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible for group, blanket or franchise insurance. The phrase "any one insurer" in this paragraph includes all the affiliated companies of a group of insurance companies under common management or control. The phrase "a particular insurance product" in this paragraph means an insurance policy that provides benefits substantially different from those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product's being offered as a different product eligible for concurrent or overlapping enrollment periods.

c. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless either is true.

37.57(2) 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 shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term "juxtaposition" means side by side or immediately above or below.

37.57(3) Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of Medicare supplement insurance.

37.57(4) An invitation to inquire, which means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reductions 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 producer or the company [whichever is applicable]."

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.58(507B,514D) Enforcement procedures—certificate of compliance. Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with the insurance division, with the insurer's annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of the authorized officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied with or were made to comply in all respects with the provisions of these rules and the laws of this state as implemented and interpreted by these rules.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.59(507B,514D) Filing for prior review. The commissioner may, at the commissioner's discretion, require the filing with the insurance division, for review prior to use, of any Medicare supplement insurance advertising material.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1]_____ SMSBP[2]_____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code_____
Address_____ Person Completing This Exhibit_____
Title_____ Telephone Number_____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a - 1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (excluding interest)	
5.	Previous Since Inception (excluding interest)	
6.	Refunds Since Inception (excluding interest)	
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)	
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.
[3] Includes Modal Loadings and Fees Charged.
[4] Excludes Active Life Reserves.
[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] × Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) - [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name (Please type.)

_____
Title (Please type.)

_____
Date

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes.

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Appendix B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C
DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Hospice
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

These rules are intended to implement Iowa Code chapters 507B and 514D.

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CHAPTER 38
COORDINATION OF BENEFITS

DIVISION I

191—38.1(509,514) Purpose.

38.1(1) The purpose of this chapter is to adopt model group coordination of benefit ("COB") provisions and uniform guidelines for their interpretation and administration as promulgated by the National Association of Insurance Commissioners.

38.1(2) This chapter is intended to establish uniformity in the permissive use of overinsurance provisions to avoid claim delays, duplication of benefits when a person is covered by two or more plans providing benefits for medical, dental, or other care or treatment, and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among plans.

191—38.2(509,514) Applicability.

38.2(1) This chapter does not require the use of overinsurance provisions in group health insurance policies or group nonprofit health service plan contracts. If, however, a policy or contract contains overinsurance provisions, those provisions must be consistent with this chapter. A plan that does not include a COB provision consistent with this rule shall not take the benefits of another plan into account when it determines benefits.

38.2(2) Overinsurance provisions, or provisions for the reduction of benefits otherwise payable because of other insurance by whatever name designated, other than the model coordination of benefit provisions of this chapter may not be used, except that plans of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

191—38.3(509,514) Definitions.

38.3(1) *Plan.*

a. A "plan" is a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the remainder of this subrule.

b. This rule uses the term "plan." However, a group contract may, instead, use "program" or some other term.

c. "Plan" shall not include individual or family:

(1) Insurance contracts;

(2) Subscriber contracts;

(3) Coverage through health maintenance organizations (HMOs); or

(4) Coverage under other prepayment, group practice and individual practice plans; except as provided below.

d. "Plan" may include:

(1) Group insurance and group subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(4) Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. This description of group-type contracts is not intended to include individually

underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

e. "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

f. "Plan" may include Medicare or other governmental benefits. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program. However, "plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

g. "Plan":

(1) Shall not be construed to include group or group-type hospital indemnity benefits of $100 per day or less; but

(2) May be construed to include the amount by which group or group-type hospital indemnity benefits exceed $100 per day. "Hospital indemnity benefits" are those not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

h. "Plan" shall not include school accident-type coverages. These cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

38.3(2) *"This plan"* is the portion of the group contract that provides health care benefits to which the COB provision applies and which may be reduced on account of the benefits of other plans.

38.3(3) *"Primary plan."* A primary plan shall mean one in which benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either paragraph *"a"* or *"b"* below is true.

a. The plan either has no order of benefit determination rules, or it has rules which differ from these.

b. All plans which cover the person use the order of benefit determination rules required by this rule, and under those rules, the plan determines its benefits first.

38.3(4) *"Secondary plan."* A secondary plan shall mean one which is not a primary plan. If a person is covered by more than one secondary plan, these order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under these rules, has its benefits determined before those of that secondary plan.

38.3(5) *"Allowable expense"* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved.

a. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, as specifically defined in the plan, or in the event the hospital lacks an available semiprivate room for the patient.

b. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

c. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "allowable expense" must include the corresponding expenses or services to which COB applies.

38.3(6) *"Claim"* means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. Services (including supplies);

b. Payment for all or a portion of the expenses incurred;

c. A combination of paragraphs *"a"* and *"b"* above; or

d. An indemnification.

38.3(7) *"Claim determination period."*

a. This is the period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine:

(1) Whether overinsurance exists; and

(2) How much each plan will pay or provide.

It usually is a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

b. As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. But that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

191—38.4(509,514) Model COB contract provision.

38.4(1) Following is a model COB provision for use in group contracts. That use is subject to the provisions of subrules 38.4(2) and 38.4(3) and to the provisions of these rules for coordination of benefits.

38.4(2) Flexibility. A group contract's COB provision does not have to use the words and format shown in this subrule. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans:

a. Which provide services;

b. Which pay benefits for expenses incurred; and

c. Which indemnify.

Substantive changes are allowed only as set forth in this rule.

38.4(3) Prohibited coordination and benefit design. A group contract may not reduce benefits on the basis that:

a. Another plan exists;

b. Except with respect to Part B of Medicare, that a person is or could have been covered under another plan; or

c. A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan defined in 38.3(1)*"a,"* except in accord with rules permitted by 191—Chapter 38.

38.4(4) Text of the model COB provision.

COORDINATION OF THE GROUP CONTRACTS
BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY.

A. This coordination of benefits *("COB")* provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(1) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section (IV), effect on the benefits of this plan.

II. DEFINITIONS.

A. *"Plan"* is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under (i) or (ii) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. *"This plan"* is the part of the group contract that provides benefits for health care expenses.

C. *"Primary plan"/"Secondary plan."* The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

D. *"Allowable expense"* means a necessary, reasonable, and customary item of expense of health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, as specifically defined in the plan, or in the event the hospital lacks an acceptable semiprivate room for the patient. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

E. *"Claim determination period"* means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES.

A. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of this plan; and

(2) Both those rules and this plan's rules, in subparagraph B below, require that this plan's benefits be determined before those of the other plan.

B. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent child/parents not separated or divorced. Except as stated in subparagraph (B)(3) below, when this plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(c) If the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent child/separated or divorced parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

(4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

(6) Longer/shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

IV. EFFECT ON THE BENEFITS OF THIS PLAN.

A. *When this section applies.* This section IV applies when, in accordance with section III, order of benefit determination rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) immediately below.

B. *Reduction in this plan's benefits.* The benefits of this plan will be reduced when the sum of:

(1) The benefits that would be payable for the allowable expenses under this plan in the absence of this COB provision; and

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceed those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

(3) When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

A. Certain facts are needed to apply these COB rules. The insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person.

B. The insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the insurer any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT.

A. A payment made under another plan may include an amount which should have been paid under this plan. If it does, the insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan.

B. The insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY.

A. If the amount of the payment made by the insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(1) The persons it has paid or for whom it has paid;

(2) Insurance companies; or

(3) Other organizations.

B. The *"amount of the payments made"* includes the reasonable cash value of any benefits provided in the form of services.

191—38.5(509,514) Order of benefits.

38.5(1) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

38.5(2) A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

38.5(3) Dependent child/parents not separated or divorced. The word "birthday" in these rules refers only to month and day in a calendar year, not the year in which a person was born.

38.5(4) Longer/shorter length of coverage. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

1. A change in the amount or scope of a plan's benefits;
2. A change in the entity which pays, provides or administers the plan's benefits; or
3. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

191—38.6(509,514) Reduction in a plan's benefits when it is secondary—general. A secondary plan may reduce its benefits subject to the conditions and limits described herein.

Total allowable expenses. A secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plans benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

191—38.7(509,514) Reasonable cash value of services. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan, and have not already been paid or provided by the primary plan. Nothing in this rule shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

191—38.8(509,514) Excess and other nonconforming provisions.

38.8(1) Some plans have order of benefit determination rules not consistent with this rule which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because a certain plan may not be subject to insurance regulation; or some group contracts have not yet been conformed with this rule.

38.8(2) A plan with order of benefit determination rules which comply with this rule (herein called a "complying plan") may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this rule, (therein called a "noncomplying plan") on the following basis:

a. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.

b. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability.

c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

d. If the noncomplying plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than they would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan; and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the difference. However, in no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid. In consideration of such advance, the complying plan shall be subrogated to all rights of the employee, subscriber, or member against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation.

191—38.9(509,514) Allowable expense. A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

191—38.10(509,514) Subrogation. The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

191—38.11(509,514) Effective date—existing contracts.

38.11(1) These rules are applicable to every group contract which provides health care benefits and is issued in Iowa.

38.11(2) A group contract which provides health care benefits and was issued prior to the effective date of these rules shall be brought into compliance by the later of:

a. The next anniversary date or renewal date of the group contract; or

b. The expiration of any applicable collectively bargained contract pursuant to which it was written.

DIVISION II

191—38.12(509,514) Purpose and applicability.

38.12(1) The purpose of this division is to adopt the new model provisions for coordination of benefits (COB) as promulgated by the National Association of Insurance Commissioners (NAIC).

38.12(2) This division is intended to establish a uniform order of benefit determination under which plans pay claims; to reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this division, do not have to pay benefits first; and to provide greater efficiency in the processing of claims when a person is covered under more than one plan.

38.12(3) These rules apply to all plans that are issued on or after January 25, 2006.

191—38.13(509,514) Definitions. As used in this division, these terms have the following meanings, unless the context clearly indicates otherwise:

"Allowable expense," except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

1. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

4. The following are examples of expenses that are not allowable expenses:

a. If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and by another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

5. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of "allowable expense" in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" shall include similar expenses to which COB applies.

6. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

7. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

"Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

"Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of services (including supplies); payment for all or a portion of the expenses incurred; a combination of services or expenses incurred; or an indemnification.

"Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

"Consolidated Omnibus Budget Reconciliation Act of 1985" or *"COBRA"* means coverage provided under a right of continuation pursuant to federal law.

"Coordination of benefits" or *"COB"* means a provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

"Custodial parent" means the parent awarded custody of a child by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

"Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group,

including blanket coverage. "Group-type contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

"High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

"Hospital indemnity benefits" means benefits not related to expenses incurred. "Hospital indemnity benefits" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

"Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in paragraph 1 below. A model COB provision is contained in Appendix A of this division.

1. "Plan" includes:

a. Group and nongroup insurance contracts and subscriber contracts;

b. Uninsured arrangements of group or group-type coverage;

c. Group and nongroup coverage through closed panel plans;

d. Group-type contracts;

e. The medical care components of long-term care contracts, such as skilled nursing care;

f. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" contracts; and

g. Medicare or other governmental benefits, as permitted by law, except as provided in paragraph 2*"h"* below. This part of a plan may be limited to the hospital, medical and surgical benefits of the governmental program.

2. "Plan" does not include:

a. Hospital indemnity coverage benefits or other fixed indemnity coverage;

b. Accident-only coverage;

c. Specified disease or specified accident coverage;

d. Limited benefit health insurance coverage, as defined in 191—subrule 36.6(10);

e. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;

f. Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

g. Medicare supplement policies;

h. A state plan under Medicaid; or

i. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

"Policyholder" means the primary insured named in a nongroup insurance policy.

"Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a "primary plan" if:

1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this division; or

2. All plans that cover the person use the order of benefit determination rules required by this division, and under those rules the plan determines its benefits first.

"Secondary plan" means a plan that is not a primary plan.

191—38.14(509,514) Use of model COB contract provision.

38.14(1) Appendix A of this division contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of subrules 38.14(2) through 38.14(4) and to rule 38.15(509,514).

38.14(2) Appendix B of this division is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. Appendix B is not intended to replace or change the provisions that are set forth in the contract. The purpose of Appendix B is to explain the process by which two or more plans will pay for or provide benefits.

38.14(3) The COB provision contained in the appendices to this division do not have to use the specific words and format shown in the appendices. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

38.14(4) A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

a. Another plan exists and the covered person did not enroll in that plan;

b. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

c. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

38.14(5) No plan may contain a provision that states that its benefits are "always excess" or "always secondary" except in accordance with this division.

38.14(6) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of rule 38.16(509,514) to determine the amount it should pay for the benefit.

38.14(7) No plan may use a COB provision or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of "plan" under rule 38.13(509,514).

191—38.15(509,514) Rules for coordination of benefits. When a person is covered by two or more plans, the order of benefit payments shall be determined as follows:

38.15(1) *Primary plans.* The primary plan shall pay or provide its benefits as if the secondary plan or plans do not exist.

a. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

b. When multiple contracts providing coordinated coverage are treated as a single plan under this division, this subrule applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this division.

c. If a person is covered by more than one secondary plan, the order of benefit determination rules of this division decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this division, has its benefits determined before those of that secondary plan.

38.15(2) *Inconsistent plans.*

a. Except as provided in paragraph *"b,"* a plan that does not contain order of benefit determination provisions that are consistent with this division is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

b. Coverage that is obtained by virtue of membership in a group and is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

38.15(3) *Consideration of other plans.* A plan may take into consideration the benefits paid or provided by another plan only when, under the provisions of this division, it is secondary to the other plan.

38.15(4) *Order of benefit determination.* Each plan determines its order of benefits using the first of the following rules that applies:

a. Nondependent or dependent.

(1) Subject to subparagraph 38.15(4)*"a"*(2), the plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(2) If the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or if both parents have the same birthday, the plan that has covered one of the parents the longest is the primary plan.

(2) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does have health care coverage, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 38.15(4)*"b"*(1) shall determine the order of benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph 38.15(4)*"b"*(1) of this paragraph shall determine the order of benefits; or

4. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the noncustodial parent; and then

(IV) The plan covering the noncustodial parent's spouse.

(3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph 38.15(4)*"b"*(1) or (2) as if those individuals were parents of the child.

c. Active employee or retired or laid-off employee.

(1) The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(2) If the other plan does not have the provision stated in subparagraph 38.15(4)*"c"*(1), and, as a result, the plans do not agree on the order of benefits, subparagraph 38.15(4)*"c"*(1) is ignored.

(3) Paragraph 38.15(4)*"c"* does not apply if the provisions of paragraph 38.15(4)*"a"* can determine the order of benefits.

d. COBRA or state continuation coverage.

(1) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state law or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state law or other federal law is the secondary plan.

(2) If the other plan does not have the provision stated in subparagraph 38.15(4)*"d"*(1), and if, as a result, the plans do not agree on the order of benefits, subparagraph 38.15(4)*"d"*(1) is ignored.

(3) Paragraph 38.15(4)*"d"* does not apply if the provisions of paragraph 38.15(4)*"a"* can determine the order of benefits.

e. Longer or shorter length of coverage.

(1) If the preceding provisions stated in paragraphs 38.15(4)*"a"* through *"d"* do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(2) To determine the length of time during which a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

(3) The start of a new plan does not include:

1. A change in the amount or scope of a plan's benefits;
2. A change in the entity that pays, provides or administers the plan's benefits; or
3. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

(4) The length of time during which a person is covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date on which the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

f. If none of the preceding provisions stated in paragraphs 38.15(4)*"a"* through *"e"* determine the order of benefits, the allowable expenses shall be shared equally between the plans.

191—38.16(509,514) Procedure to be followed by secondary plan to calculate benefits and pay a claim. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

191—38.17(509,514) Notice to covered persons. A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

191—38.18(509,514) Miscellaneous provisions.

38.18(1) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this subrule shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

38.18(2) Complying and noncomplying plans.

a. A plan with order of benefit determination provisions that comply with this division (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this division (noncomplying plan) on the following basis:

(1) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(2) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(3) If the noncomplying plan does not provide the information needed by the complying plan to determine the complying plan's benefits within a reasonable time after the noncomplying plan is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, the complying plan shall adjust payments accordingly.

b. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

c. In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

38.18(3) COB differs from subrogation. Provisions for COB or subrogation may be included in health care benefits contracts without compelling the inclusion or exclusion of either.

38.18(4) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

191—38.19(509,514) Effective date for existing contracts.

38.19(1) A contract that provides health care benefits and that was issued before January 25, 2006, shall be brought into compliance with this division by the latest of:

a. The next anniversary date or renewal date of the contract; or

b. Twelve months following January 25, 2006; or

c. The expiration of any applicable collectively bargained contract pursuant to which it was written.

38.19(2) For the transition period between the adoption of this division and the time frame for which plans are to be in compliance pursuant to subrule 38.19(1), a plan that is subject to the COB requirements in division I shall not be considered a noncomplying plan by a plan subject to the new COB requirements in division II. If there is a conflict between the COB requirements in division I and the new COB requirements in division II, the COB requirements in division I shall apply.

APPENDIX A MODEL COB CONTRACT PROVISIONS

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payment from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other

similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and by another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other **Plan**.

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Nondependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
- If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child is as follows:

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **Noncustodial parent**; and then
- The **Plan** covering the spouse of the **Noncustodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility for **COB** administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for **COB** administration] is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan Is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

or

- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

or

- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain precertification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

These rules are intended to implement Iowa Code chapters 509 and 514.

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CHAPTER 39
LONG-TERM CARE INSURANCE

DIVISION I

191—39.1(514G) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514G, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

191—39.2(514G) Authority. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code section 514G.7 in accordance with the procedures set forth in Iowa Code chapter 17A.

191—39.3(514G) Applicability and scope. Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies and long-term care coverage arrangements delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

191—39.4(514G) Definitions. For the purpose of these rules, the terms *"Group long-term care insurance," "Commissioner," "Applicant," "Policy," "Preexisting condition"* and *"Certificate"* shall have the meanings set forth in Iowa Code chapter 514G, "Long-Term Care Insurance Act."

"Long-term care insurance" means an insurance policy, insurance contract, insurance certificate, or rider, which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital. This definition also encompasses group and individual annuities and life insurance policies or riders that provide directly for or supplement long-term care insurance as well as a policy or rider providing for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare Supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset-protection coverage, or accident-only coverage, specific disease or specified accident coverage, or limited benefit health coverage. The definition does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor eligibility for those benefits is conditional upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of 191—Chapter 39.

"Long-term care coverage arrangement" is a promise that long-term care will be delivered to a person upon need and the meeting of certain contractual requirements. The arrangement is offered to the general public or a sector of the general public at a cost determined by the use of sound actuarial principles based upon the probability of use. This definition does not include self-insurance.

"Qualified long-term care insurance contract" or *"federally tax-qualified long-term care insurance contract"* means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments

being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed;

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986.

191—39.5(514G) Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

39.5(1) *"Medicare"* shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

39.5(2) *"Mental or nervous disorder"* shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

39.5(3) *Nursing care.*

a. *"Skilled nursing care"* shall not be defined more restrictively than one or more professional services performed for the benefit of the insured on a daily basis, by or under the supervision of a registered nurse, prescribed by a physician, appropriate and consistent with the diagnosis and conditions requiring care.

b. *"Intermediate nursing care"* shall not be defined more restrictively than care which meets all of the above when professional nursing services are delivered on a regular basis but less often than daily.

c. *"Custodial nursing care"* shall not be defined more restrictively than that level of care required to assist an individual in activities of daily living when, due to age complicated by sickness or injury, such care is required. This level of care can be performed by persons without professional skills or training.

39.5(4) *"Nursing facility"* shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law; be appropriately licensed or certified;

(2) Be primarily engaged in providing, in addition to room and board accommodations, skilled or intermediate nursing care under the supervision of a duly licensed physician;

(3) Provide nursing service by or under the supervision of a registered nurse (R.N.); and

(4) Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not include:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

39.5(5) *"Acute condition"* means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

39.5(6) *"Home health care services"* means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

39.5(7) *"Activities of daily living"* means at least bathing, continence, dressing, eating, toileting and transferring.

39.5(8) *"Adult day care"* means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

39.5(9) *"Bathing"* means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

39.5(10) *"Cognitive impairment"* means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

39.5(11) *"Continence"* means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

39.5(12) *"Dressing"* means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

39.5(13) *"Eating"* means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

39.5(14) *"Exceptional increase"* means only those increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in rule 191—39.28(514G), exceptional increases are subject to the same requirements as other premium rate schedule increases.

The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

39.5(15) *"Hands-on assistance"* means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

39.5(16) *"Incidental,"* as used in subrule 39.28(10), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

39.5(17) *"Personal care"* means the provision of hands-on services to assist an individual with activities of daily living.

39.5(18) *"Qualified actuary"* means a member in good standing of the American Academy of Actuaries.

39.5(19) *"Similar policy forms"* means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Iowa Code section 514G.4(4) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar

policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

39.5(20) *"Toileting"* means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

39.5(21) *"Transferring"* means moving into or out of a bed, chair or wheelchair.

191—39.6(514G) Policy practices and provisions.

39.6(1) *Renewability.* The terms *"guaranteed renewable"* and *"noncancellable"* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of this chapter. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

a. The term *"guaranteed renewable"* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew. Rates may be revised by the insurer on a class basis.

b. The term *"noncancellable"* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

c. Notwithstanding the provisions in 191—subrule 36.5(4), long-term care insurance policies may contain a return of premium or cash value benefit so long as:

(1) The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

(2) The insurer demonstrates in its filings that the reserve basis for the policies is adequate.

Any advertisement or sales presentation of a long-term care insurance policy with a return of premium or cash value benefit provision shall include a side-by-side comparison of premiums for the same policy with and without the return of premium or cash value benefit provision.

d. The term "level premium" may be used only when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subrule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.

39.6(2) *Limitations and exclusions.*

a. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or disease;

(2) Mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or similar forms of irreversible dementia nor limit coverage for Alzheimer's disease to the skilled or intermediate level of care);

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

1. War or act of war (whether declared or undeclared);
2. Participation in a felony, riot or insurrection;
3. Service in the armed forces or units auxiliary thereto;
4. Attempted suicide (sane or insane) or intentional self-inflicted injury;
5. Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

Paragraph *"a"* is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

b. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Iowa Code section 514G.7(3)*"b"* expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Iowa Code section 514G.7(3)*"b."*

c. No long-term care insurance policy may be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

39.6(3) *Extension of benefits.* Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

39.6(4) *Continuation or conversion.*

a. Group long-term care insurance issued in this state on or after January 1, 1992, shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this rule, *"a basis for continuation of coverage"* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

c. For the purposes of this rule, *"a basis for conversion of coverage"* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this rule, *"converted policy"* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the

group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than 31 days after termination, by group coverage, effective on the day following termination of coverage, that provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage, and for which the premium is calculated in a manner consistent with the requirements of paragraph *"f"* of this subrule.

h. Notwithstanding any other provision of this rule, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this rule, any insured individual whose eligibility for long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purpose of this rule: a *"Managed-Care Plan"* is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

39.6(5) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

39.6(6) *Premiums.*

a. The premiums charged to an insured for long-term care insurance shall not increase due to either:

(1) The increasing age of the insured at ages beyond 65; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under subrule 39.29(6), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under subrule 39.29(6), the initial annual premium shall be based on the reduced benefits.

39.6(7) *Electronic enrollment for group policies.* In the case of a group defined in Iowa Code section 514G.4(4), any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information is maintained.

The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

191—39.7(514G) Required disclosure provisions.

39.7(1) *Renewability.*

a. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

b. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

39.7(2) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, no riders or endorsements may be added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

39.7(3) *Payment of benefits.* A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

39.7(4) *Limitations.* If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

39.7(5) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in Iowa Code section 514G.7(4)*"b,"* shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

39.7(6) *Disclosure of tax consequences.* With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subrule shall not apply to qualified long-term care insurance contracts.

39.7(7) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of

the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too shall be specified.

39.7(8) *Qualified long-term care contracts.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

39.7(9) *Nonqualified long-term care contracts.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

191—39.8(514G) Prohibition against postclaims underwriting.

39.8(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

39.8(2) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

39.8(3) Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

39.8(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate.

39.8(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners.

191—39.9(514D,514G) Minimum standards for home health care benefits in long-term care insurance policies.

39.9(1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

a. By requiring that the insured/claimant would need skilled care in a nursing facility if home health care services were not provided;

b. By requiring that the insured/claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the provider's licensure or certification;

e. By requiring that the insured/claimant have an acute condition before home health care services are covered;

f. By limiting benefits to services provided by Medicare-certified agencies or providers;

g. By excluding coverage for personal care services provided by a home health aide;

h. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

i. By excluding coverage for adult day care services.

39.9(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.10(514D,514G) Requirement to offer inflation protection.

39.10(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offers, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

39.10(2) Where the policy is issued to a group, the required offer in subrule 39.10(1) shall be made to the group policyholder; except, if the policy is issued to a group defined in Iowa Code section 514G.4(5)*"d,"* other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

39.10(3) The offer in subrule 39.10(1) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

39.10(4) Insurers shall include the following information in or with the outline of coverage:

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

39.10(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

39.10(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

39.10(7) Inflation protection as provided in this subrule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subrule. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.11(514D,514G) Requirements for application forms and replacement coverage.

39.11(1) Application forms shall include the following questions designed to elicit information whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by Iowa Code section 514G.4(5)*"a,"* the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(1) If so, with which company?

(2) If that policy lapsed, when did it lapse?

c. Are you covered by Medicaid?

d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

39.11(2) Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

39.11(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides ten days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT
[BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]
The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

39.11(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

39.11(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

39.11(6) Life insurance policies that accelerate benefits for long-term care shall comply with this subrule if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 191—Chapter 16. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.12(514G) Reserve standards.

39.12(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Iowa Code section 508.36(3)*"a"*(7). Claim reserves must also be established when such policy or rider is in claim status.

Reserves for policies and riders subject to this subrule should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to the subrule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

a. Definition of insured events;

b. Covered long-term care facilities;

c. Existence of home convalescence care coverage;

d. Definition of facilities;
e. Existence or absence of barriers to eligibility;
f. Premium waiver provision;
g. Renewability;
h. Ability to raise premiums;
i. Marketing method;
j. Underwriting procedures;
k. Claims adjustment procedures;
l. Waiting period;
m. Maximum benefit;
n. Availability of eligible facilities;
o. Margins in claim costs;
p. Optional nature of benefit;
q. Delay in eligibility for benefit;
r. Inflation protection provisions; and
s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

39.12(2) When long-term care benefits are provided other than as in subrule 39.12(1), reserves shall be determined in accordance with sound actuarial standards, applied consistently and accepted by the commissioner of insurance.

191—39.13(514D) Loss ratio.

39.13(1) *Applicability.* This rule shall apply to all long-term care insurance policies or certificates except those covered under rules 191—39.26(514G) and 191—39.28(514G).

39.13(2) *Minimum loss ratio.* Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors including:

a. Statistical credibility of incurred claims experience and earned premiums.
b. The period for which rates are computed to provide coverage.
c. Experienced and projected trends.
d. Concentration of experience within early policy duration.
e. Expected claim fluctuation.
f. Experience refunds, adjustments or dividends.
g. Renewability features.
h. All appropriate expense factors.
i. Interest.
j. Experimental nature of the coverage.
k. Policy reserves.
l. Mix of business by risk classification.
m. Product features such as long elimination periods, high deductibles and high maximum limits.

39.13(3) *Accelerated benefits.* Subrule 39.13(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Iowa Code section 508.37;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The policy illustration meets the applicable requirements of 191—Chapter 14 regarding illustrations; and

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

191—39.14(514G) Filing requirement. Prior to an insurer or similar organization's offering group long-term care insurance to a resident of this state pursuant to Iowa Code section 514G.4(5)*"d,"* it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

191—39.15(514D,514G) Standards for marketing.

39.15(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies by its agents or other producers will be fair and accurate.

b. Establish marketing procedures to ensure that excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subrule.

f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program.

g. For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph 39.6(1)*"b."*

h. Provide an explanation of contingent benefit upon lapse provided for in 39.29(6)*"c."*

39.15(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. High-pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold-lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

39.15(3) Association marketing.

a. When a group long-term care insurance policy is issued to an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations, the association or associations, or the insurer of the association or associations, shall, prior to advertising, marketing or offering the policy within this state, file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

b. When a professional, trade, or occupational association is issued a group long-term care policy for its members or retired members or combination thereof, the association shall have as its primary responsibility, when endorsing or selling long-term care insurance, to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(1) The insurer shall file with the insurance division the following material:

1. The policy and certificate;
2. A corresponding outline of coverage; and
3. All advertisements requested by the insurance division.

(2) The association shall disclose in any long-term care insurance solicitation the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and a brief description of the process under which the policies and the insurer issuing the policies were selected.

(3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(4) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(5) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

2. Actively monitor the marketing efforts of the insurer and its agents; and

3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Numbered paragraphs "1" through "3" shall not apply to qualified long-term care insurance contracts.

(6) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the insurance division the information required in this subrule.

(7) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subrule.

(8) Failure to comply with the filing and certification requirements of this subrule constitutes an unfair trade practice in violation of Iowa Code chapter 507B.

39.15(4) *Producer training requirements.*

a. Purpose. The purpose of this subrule is to require certain specific minimum training for insurance producers who wish to sell long-term care insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance products and to ensure that insurance producers are able to determine whether long-term care insurance products are suitable for consumers and that producers are able to adequately explain to consumers how the long-term care insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance products understand basic features of the products. This subrule applies to all long-term care insurance products sold on or after January 1, 2009.

b. Requirements for insurers. An insurer subject to this subrule shall obtain verification that a producer has received training required by this subrule before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products.

c. Required training. The training required by paragraph *"b"* is as follows:

(1) To sell, solicit or negotiate long-term care insurance for an insurer on or after January 1, 2009, a producer must have completed a one-time training course of at least four credits and as set forth in paragraph *"d."*

(2) In addition to the one-time training course required in subparagraph (1) to sell, solicit or negotiate long-term care insurance for an insurer on or after January 1, 2009, a producer shall complete ongoing training of no less than three credits every CE term and as set forth in paragraph *"d."*

(3) For purposes of this subrule, "credit" and "CE term" shall be defined as they are defined in rule 191—11.2(505,522B).

d. Training content. The training required under this subrule shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care asset preservation programs, pursuant to 191—Chapter 72, including, but not limited to:

(1) State and federal regulations and requirements and the relationship between qualified state long-term care asset preservation programs and other public and private coverage of long-term care services, including Medicaid;

(2) Available long-term care services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of private long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection; and

(6) Consumer suitability standards and guidelines.

e. General training. The training required by this subrule shall not include training that is specific to an insurer's or company's product or that includes any sales or marketing information, materials, or training, other than that required by state or federal law.

f. Approval of courses. The training requirements of paragraph *"c"* must be approved as continuing education courses under 191—Chapter 11.

g. Maintenance of records. An insurer subject to this subrule shall maintain records in accordance with the state's record retention requirements.

h. Training obtained from another insurer. An insurer may use verification from another insurer or another provider that a producer has received the required training for the purpose of meeting the requirements of this subrule.

i. Records available to commissioner. An insurer subject to this subrule shall make the verification and records available to the commissioner upon request.

j. Training obtained in other states. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this state.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.16(514D,514G) Suitability.

39.16(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

39.16(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

b. Train its agents in the use of its suitability standards; and

c. Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

39.16(3) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take into consideration the following:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

39.16(4) The issuer, and, when an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subrule 39.16(3). The efforts shall include presentation of the "Long-Term Care Insurance Personal Worksheet" to the applicant, at the time of or prior to application. The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

39.16(5) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

39.16(6) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

39.16(7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than 12-point type.

39.16(8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's

intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

39.16(9) The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

191—39.17(514G) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

191—39.18(514G) Standard format outline of coverage. This rule, which is not applicable to life policies with long-term care riders attached, implements, interprets and makes specific the provisions of Iowa Code section 514G.7(1) in prescribing a standard format and the content of an outline of coverage.

39.18(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

39.18(2) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

39.18(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

39.18(4) The commissioner shall prescribe the standard format, including style, arrangement, and overall appearance and content of an outline of coverage.

39.18(5) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

39.18(6) The outline of coverage shall contain no material of an advertising nature.

39.18(7) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

39.18(8) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

39.18(9) Format for outline of coverage:

[COMPANY NAME]
[ADDRESS — CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or substantially similar language, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [[a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a

summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief, specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in "6" above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. This policy does not qualify for Medicaid asset protection under the Iowa Long-Term Care Asset Preservation Program. However, this policy is an approved Long-Term Care Insurance Policy under state regulations. For information about policies and certificates qualifying under the Iowa Long-Term Care Asset Preservation Program, contact the Senior Health Insurance Information Program of the Insurance Division at 1-800-351-4664.**

16. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM (800-351-4664)** IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

**Outlines of coverage must be updated to include the listed number for the Senior Health Insurance Information Program no later than August 1, 2003. Insurers may continue to use Outlines that list the telephone number of 515-281-5705 until July 31, 2003.

191—39.19(514G) Requirement to deliver shopper's guide.

39.19(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, the Health Insurance Association of America or the senior health insurance information program of the insurance division shall be provided to all prospective applicants of a long-term care insurance policy or certificate or life insurance policy or certificate that includes a long-term care rider.

a. In the case of agent solicitations, an agent must deliver the shopper's guide to the applicant at the time of application.

b. In the case of direct response solicitations, the shopper's guide must be presented to the applicant at the time the policy is delivered.

39.19(2) Insurers offering life insurance policies or riders containing accelerated long-term care benefits are not required to comply with 39.19(1), but shall furnish the policy summary required under rule 191—39.20(514G).

191—39.20(514G) Policy summary and delivery of life insurance policies with long-term care riders.

39.20(1) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

39.20(2) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions, and limitations on benefits of long-term care;

d. If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

e. A statement that any long-term care inflation protection option required by rule 191—39.10(514D,514G) is not available under this policy.

The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with 191—Chapter 14 or into the life insurance policy summary which is required to be delivered in accordance with rule 191—15.4(507B).

191—39.21(514G) Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit. Any time a long-term care benefit, funded through life insurance which by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

1. Any long-term care benefits paid out during the month;
2. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and
3. The amount of long-term care benefits existing or remaining.

191—39.22(514G) Unintentional lapse.

39.22(1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation no less often than once every two years.

39.22(2) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subrule 39.22(1) need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

39.22(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subrule 39.22(1) at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

39.22(4) Reinstatement. In addition to the requirement in subrule 39.22(1), a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

191—39.23(514G) Denial of claims. If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof, provide a written explanation of the reasons for the denial; and make available all information directly related to the denial.

191—39.24(514G) Incontestability period.

39.24(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

39.24(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

39.24(3) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

39.24(4) No long-term care insurance policy or certificate may be field-issued based on medical or health status. For purposes of this subrule, "field-issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

39.24(5) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

39.24(6) In the event of the death of the insured, this rule shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by Iowa Code section 508.28. In all other situations, this rule shall apply to life insurance policies that accelerate benefits for long-term care.

191—39.25(514G) Required disclosure of rating practices to consumers.

39.25(1) *Applicability.* This rule applies to any new long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force prior to February 1, 2003, the provisions of this rule shall apply on the policy anniversary following February 1, 2003.

39.25(2) *Contents of disclosure.* Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subrule to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subrule to the applicant no later than at the time of delivery of the policy or certificate.

a. A statement that the policy may be subject to rate increases in the future;

b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

d. A general explanation for applying premium rate or rate schedule adjustments that shall include:

(1) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(2) The right to a revised premium rate or rate schedule as provided in paragraph 39.25(2)*"c"* if the premium rate or rate schedule is changed;

e. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state.

(1) The following, at a minimum, shall be included:

1. The policy forms for which premium rates have been increased;
2. The calendar years when the form was available for purchase; and
3. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(3) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or on a block of policy forms acquired from nonaffiliated insurers on or before the later of February 1, 2003, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the non-affiliated selling company shall include the disclosure of that rate increase in accordance with paragraph *"e."*

(5) If the acquiring insurer in subparagraph (4) above files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (4), the acquiring insurer shall make all disclosures required by paragraph *"e,"* including disclosure of the earlier rate increase referenced in subparagraph (4).

39.25(3) *Acknowledgment.* An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under 39.25(2)*"a"* and 39.25(2)*"e."* If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

39.25(4) *Required format.* An insurer shall use the forms in Appendices B and F to comply with the requirements of this rule.

39.25(5) *Notice of rate increase.* An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subrule 39.25(2) when the rate increase is implemented.

191—39.26(514G) Initial filing requirements.

39.26(1) *Effective date.* This rule applies to any long-term care policy issued in this state on or after February 1, 2003.

39.26(2) *Required filing.* An insurer shall provide the information listed in this subrule to the commissioner pursuant to rule 191—20.1(505,509,514A,515,515A,515F) 30 days prior to making a long-term care insurance form available for sale.

a. A copy of the disclosure documents required in rule 191—39.25(514G); and

b. An actuarial certification consisting of at least the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

1. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

2. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

3. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

4. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

- An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
- If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subrule 39.26(3) based on a standard age distribution; and

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

39.26(3) *Demonstration on request.*

a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

b. In the event the commissioner asks for additional information under this provision, the period in subrule 39.26(2) does not include the period during which the insurer is preparing the requested information.

191—39.27(514G) Reporting requirements.

39.27(1) Every insurer shall maintain for each agent records of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

39.27(2) Every insurer shall report annually by June 30 the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by subrule 39.27(1) in the format prescribed in Appendix G.

39.27(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

39.27(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year in the format prescribed in Appendix G.

39.27(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year in the format prescribed in Appendix G.

39.27(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied in the format prescribed in Appendix E.

39.27(7) For purposes of rule 191—39.27(514G):

a. "Policy" means only long-term care insurance;

b. Subject to paragraph *"c"* below, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

c. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

d. "Report" means on a statewide basis.

39.27(8) Reports required under this rule shall be filed with the commissioner. The first reports under this rule are due June 30, 2004.

191—39.28(514G) Premium rate schedule increases.

39.28(1) This rule applies to any long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall apply on the policy anniversary following July 1, 2003.

39.28(2) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders and shall include:

a. Information required by rule 191—39.25(514G);

b. Certification by a qualified actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(2) The premium rate filing is in compliance with the provisions of this rule;

c. An actuarial memorandum justifying the rate schedule change request that includes:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

1. Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

2. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

3. The projections shall demonstrate compliance with subrule 39.28(3); and

4. For exceptional increases,

- The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
- In the event the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;

(2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(4) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

e. Sufficient information for review of the premium rate schedule increase by the commissioner.

39.28(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

a. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium multiplied by 58 percent;

(2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums multiplied by 58 percent; and

(4) Eighty-five percent of the present value of future projected premiums not in subparagraph (3) above on an earned basis;

c. In the event that a policy form has both exceptional and other increases, the values in subparagraphs 39.28(3)*"b"*(2) and (4) will also include 70 percent for exceptional rate increase amounts; and

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as recommended by the NAIC Financial Examiners Handbook. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

39.28(4) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in subparagraph 39.28(2)*"c"*(1), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this subrule shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(5) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subparagraph 39.28(2)*"c"*(1), shall be filed for review by the commissioner every five years following the end of the required period in subrule 39.28(4). For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(6) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subrule 39.28(3), the commissioner may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to subparagraph 39.28(2)*"c"*(5), if applicable.

39.28(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subrule 39.28(8); and

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subrule 39.28(3) had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs 39.28(3)*"b"*(1) and (3).

39.28(8) Review of lapse rates.

a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

b. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

1. Be subject to the approval of the commissioner;
2. Be based on actuarially sound principles, but not be based on attained age; and
3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

39.28(9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subrule 39.28(8), prohibit the insurer from either of the following:

a. Filing and marketing comparable coverage for a period of up to five years; or

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

39.28(10) Subrules 39.28(1) through 39.28(9) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subrule 39.5(16), if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(1) Iowa Code section 508.37, regarding nonforfeiture standards for life insurance;

(2) Iowa Code section 508.38, regarding nonforfeiture standards for individual deferred annuities; and

(3) Iowa Code section 508A.5 and 191—subrule 31.3(8), regarding variable annuities;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required by 191—Chapter 14;

(2) Disclosure requirements for annuities as required by the commissioner; and

(3) Disclosure requirements for variable annuities as required by 191—Chapter 31;

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

39.28(11) Subrules 39.28(6) and 39.28(8) shall not apply to group insurance policies where:

a. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

191—39.29(514G) Nonforfeiture.

39.29(1) Except as provided in subrule 39.29(2), a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

39.29(2) When a group long-term care insurance policy is issued, the offer required in subrule 39.29(1) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group as defined in Iowa Code section 514G.4(4)*"d,"* other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

39.29(3) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

39.29(4) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of subrule 39.29(1):

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subrule 39.29(7); and

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

39.29(5) If the offer required to be made under subrule 39.29(1) is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

39.29(6) Benefit triggers.

a. After rejection of the offer required under subrule 39.29(1), for individual and group policies without nonforfeiture benefits issued after February 1, 2003, the insurer shall provide a contingent benefit upon lapse.

b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

c. The contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless

otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

d. On or before the effective date of a substantial premium increase as defined in paragraph 39.29(6)*"c,"* the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subrule 39.29(7). This option may be elected at any time during the 120-day period referenced in paragraph 39.29(6)*"c"*; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph 39.29(6)*"c"* shall be deemed to be the election of the offer to convert in subparagraph (2) above.

39.29(7) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subrule.

a. For purposes of this subrule, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

b. For purposes of this subrule, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph *"c."*

c. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subrule 39.29(8).

d. Benefit dates.

(1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding subparagraph (1), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

1. The end of the tenth year following the policy or certificate issue date; or
2. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

39.29(8) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

39.29(9) There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual policies.

39.29(10) The requirements set forth in this rule shall become effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to any long-term care policy issued on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall not apply.

39.29(11) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 39.13(2) or 191—39.28(514G), whichever applies, treating the policy as a whole.

39.29(12) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 39.29(6)*"c,"* a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on

the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

39.29(13) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

a. The nonforfeiture provision shall be appropriately captioned;

b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium-paying contracts approved by the commissioner for the same contract form; and

c. The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;

(3) Shortened benefit period; or

(4) Other similar offerings approved by the commissioner.

39.29(14) Notwithstanding subrule 39.29(10), if an insurer requests a premium rate increase on any long-term care policy issued prior to February 1, 2003, the commissioner shall require as a condition of approval of such premium rate increase that the insurer provide notice to all affected policyholders and certificate holders that, in lieu of the requested premium rate increase, the insured may opt for one of the following:

a. A reduced benefit. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. The reduced benefit offered may include one or more of the following:

(1) A reduced daily, weekly, or monthly benefit;

(2) A longer waiting period;

(3) A reduced benefit period or a reduced maximum lifetime benefit; or

(4) Any other benefit or coverage reduction option consistent with the policy or certificate design or the carrier's administrative processes.

b. A contingent benefit upon lapse as described in subrules 39.29(7), 39.29(8), 39.29(9), and 39.29(12) if the requested premium rate increase results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in paragraph 39.29(6)*"c."*

c. Any other alternative mechanism filed by the insurer and approved by the commissioner.

191—39.30(514G) Standards for benefit triggers.

39.30(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

39.30(2) Activities of daily living.

a. Activities of daily living shall include at least the following as defined in rule 191—39.5(514G) and in the policy:

(1) Bathing;

(2) Continence;

(3) Dressing;

(4) Eating;

(5) Toileting; and

(6) Transferring.

b. Insurers may use other activities of daily living to trigger covered benefits as long as the activities are defined in the policy.

39.30(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subrules 39.30(1) and 39.30(2).

39.30(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

39.30(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

39.30(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

39.30(7) The requirements set forth in this rule shall be effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to a long-term care policy issued in this state on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy as defined in Iowa Code section 514G.4(4)*"a"* that was in force on February 1, 2003, the provisions of this rule shall not apply.

191—39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts.

39.31(1) For purposes of this rule, the following definitions apply:

"Chronically ill individual" has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

1. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

"Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(2) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

39.31(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subrule 39.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

39.31(5) Certifications required pursuant to subrule 39.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

39.31(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

191—39.32(514G) Penalties. Violations of this chapter shall be subject to the penalties imposed under Iowa Code chapter 507B.

191—39.33 to **39.40** Reserved.

DIVISION II
INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

191—39.41(514G) Purpose. This division is intended to implement Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, to provide a uniform process for insureds covered under long-term care insurance to request an independent review of a denial of coverage based on a benefit trigger determination.

191—39.42(514G) Effective date. The rules contained in this division shall apply to all requests for benefit trigger determinations made on or after January 1, 2009.

191—39.43(514G) Definitions. For purposes of this division, the definitions found in 2008 Iowa Acts, House File 2694, section 4, shall apply.

191—39.44(514G) Notice of benefit trigger determination and content. The notice required by 2008 Iowa Acts, House File 2694, section 10, shall contain the following information:

1. The reason that the insurer determined that the policy benefit trigger has not been met by the insured.
2. A description of the internal appeal mechanism provided under the long-term care policy.
3. A description of how the insured, after exhausting the insurer's internal appeal process, has the right to have the benefit trigger determination reviewed under the independent review process required by 2008 Iowa Acts, House File 2694, section 11.

191—39.45(514G) Notice of internal appeal decision and right to independent review. Upon the conclusion of the internal appeal mechanism specified in 2008 Iowa Acts, House File 2694, section 10, the notice required in 2008 Iowa Acts, House File 2694, section 10, shall contain the following information:

39.45(1) A description of additional internal appeal rights, if any, offered by the insurer.

39.45(2) A description of how the insured can request independent review of the benefit trigger determination. Such description must specify the following:

a. The insured must submit a written request within 60 days of the insured's receiving written notice of the insurer's internal appeal decision;

b. The request must be made to the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319;

c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review;

d. A $25 filing fee is required unless the insured is requesting that the fee be waived. The check should be made payable to the Iowa Insurance Division. If a waiver is requested, the request shall include an explanation for the insured's request that the fee be waived.

191—39.46(514G) Independent review request.

39.46(1) The insured shall send a copy of the insurer's notice explaining why the benefit trigger has not been met, with the insured's request for an independent review, to the insurance commissioner within 60 days of receipt of the benefit trigger determination. The notice shall be sent to the commissioner at the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319.

39.46(2) A $25 filing fee shall be enclosed with the independent review request. The commissioner may waive the fee for good cause.

191—39.47(514G) Certification process.

39.47(1) The commissioner shall provide written notice of the certification decision to the insurer and the insured within the two-business-day period specified in 2008 Iowa Acts, House File 2694, section 11.

39.47(2) The insurer may appeal the commissioner's certification decision within three business days after receiving notice of the decision. The commissioner shall review any such appeal and promptly notify the insured and the insurer of the commissioner's decision.

191—39.48(514G) Selection of independent review entity.

39.48(1) Within three business days of receiving the commissioner's certification decision, the insurer shall:

a. Select an independent review entity from the list certified by the commissioner;

b. Notify the insured in writing of the name, address, and telephone number of the independent review entity;

c. Notify the independent review entity of its selection and provide the independent review entity with sufficient information to allow selection of qualified licensed health care professionals to conduct the independent review;

d. Provide the commissioner with copies of the notices required by this subrule.

39.48(2) Within three business days of receiving the notice specified in subrule 39.48(1), the independent review entity shall do one of the following:

a. Accept its selection, designate a qualified licensed health care professional to perform the independent review, and notify the insured and insurer, with a copy to the commissioner, of the designation, the qualifications of the qualified licensed health care professional, and the reasons why the licensed health care professional is qualified to conduct the independent review;

b. Decline its selection and provide notice to the commissioner, the insured, and the insurer of the declination. The insurer shall have three business days after receipt of the declination notice to designate a different independent review entity pursuant to subrule 39.48(1); or

c. Request that the commissioner grant the independent review entity additional time to have a qualified licensed health care professional certified and provide notice of such request to the insured, the insurer, and the commissioner. Within three business days of such a request, the commissioner shall notify the insured, the insurer, and the independent review entity how to proceed.

39.48(3) Within ten days of receiving the notice specified in paragraph 39.48(1)*"b,"* an insured may object to the independent review entity selected by the insurer or the licensed health care professional selected by the independent review entity. Such an objection shall state the reasons for the objection

with particularity. The objection shall be sent to the commissioner, and a copy shall be sent to the insurer. The commissioner shall notify the insured, the insurer, and the independent review entity of the commissioner's decision within two business days of receipt of the objection.

191—39.49(514G) Independent review process.

39.49(1) Within five business days of receiving either the notice provided in paragraph 39.48(1)*"b,"* or the denial of an objection made pursuant to subrule 39.48(3), whichever is later, the insured may submit any additional information or documentation in support of the insured's claim to both the independent review entity and the insurer.

39.49(2) Within 15 days of receiving the notice provided in paragraph 39.48(1)*"b,"* or within three business days of receiving notice of the denial of an objection made pursuant to subrule 39.48(3), whichever is later, an insurer shall:

a. Provide the independent review entity with any information submitted to the insurer by the insured during the insurer's internal appeal process relating to the benefit trigger determination that is the subject of the independent review proceeding;

b. Provide the independent review entity with any other relevant documents used by the insurer in making its benefit trigger determination; and

c. Provide the commissioner and the insured with confirmation that the information required by this subrule was submitted to the independent review entity, including the date such information was submitted.

39.49(3) The independent review entity shall not commence its review of the insurer's benefit trigger determination until 15 business days after either the independent review entity receives the notice of its selection specified in paragraph 39.48(1)*"c"* or the resolution of any objection made pursuant to subrule 39.48(3), whichever is later.

39.49(4) During the time period specified in subrule 39.48(3), the insurer may consider any information provided by the insured pursuant to subrule 39.49(1) and affirm or overturn the insurer's benefit trigger determination. If the insurer overturns its benefit trigger determination:

a. The insurer shall provide notice to the independent review entity, the commissioner, and the insured of the insurer's decision; and

b. The independent review process shall immediately cease.

191—39.50(514G) Decision notification.

39.50(1) The independent review entity shall immediately notify the insurer, the insured, and the commissioner of the independent review decision either affirming or overturning the insurer's benefit trigger determination. The initial notification shall be delivered by telephone or fax transmission, and a written copy of the decision notification delivered by regular mail. The written copy of the decision shall include a description of the basis for the independent review entity's decision.

39.50(2) If the independent review entity overturns the insurer's decision, the independent review entity shall include all of the following in the decision:

a. The precise date that the benefit trigger was deemed to have been met;

b. The specific period of time under review for which the insurer declined eligibility but during which the independent review entity determined that the benefit trigger was met;

c. For qualified long-term care insurance contracts, a certification made only by a licensed health care practitioner that the insured is a chronically ill individual.

191—39.51(514G) Insurer information.

39.51(1) No later than January 1, 2009, each insurer delivering or issuing for delivery long-term care insurance policies in this state on or after July 1, 2008, and each insurer that has active long-term care policies or riders under which claims for benefits may be made on or after July 1, 2008, shall provide the commissioner the name or title, telephone and fax numbers and E-mail address of an individual who shall be the insurer's contact person for independent review procedures and matters. Any changes in personnel or communication numbers shall be immediately communicated to the commissioner.

39.51(2) Each insurer shall provide the commissioner a detailed description of the process that the insurer has in place to ensure compliance with the requirements of this division and of 2008 Iowa Acts, House File 2694, sections 10 and 11. The description required by this subrule shall be filed in a format as directed by the commissioner on or before March 1, 2009, and thereafter as requested by the commissioner. The description shall include:

a. An explanation of how the insurer determines when an insured has qualified for independent review of the benefit trigger decision and should receive a notice from the insurer,

b. A copy of the notice sent to insureds who fall within the scope of the law, and

c. An explanation of the internal appeal process.

191—39.52(514G) Certification of independent review entity. The following minimum standards are required for certification as an independent review entity:

39.52(1) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding holds a current unrestricted license or certification to practice a health care profession in the United States.

39.52(2) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(3) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is not a physician holds a current certification in the specialty in which that person is licensed by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(4) The entity shall ensure that any licensed health care professionals on its staff who participate in an independent review proceeding have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

39.52(5) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, receive compensation of any type that is dependent on the outcome of the review.

39.52(6) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

39.52(7) The entity shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewers' employment histories and practice affiliations for at least the prior ten years, and a description of past experience with decisions relating to long-term care, functional capacity, and dependency in activities of daily living, or in assessing cognitive impairment.

39.52(8) The entity shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately: licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment; and knowledgeable and experienced in diagnosing a person as a "chronically ill individual" as defined in Section 7702B(c)(2) of the Internal Revenue Code.

39.52(9) The entity shall provide a description of the evaluation tools the entity would use to conduct a review of a long-term care insurance benefit trigger decision.

39.52(10) The entity shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

39.52(11) The entity shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

39.52(12) The entity shall provide a description of the policies and procedures employed to protect confidentiality of individual personally identifiable health information in accordance with applicable state and federal laws.

39.52(13) The entity shall provide a description of the quality assurance program established by the independent review entity.

39.52(14) The entity shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the entity, and the nature and extent of any such ownership or control. The entity must ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

39.52(15) The entity shall provide the names and résumés of all directors, officers and executives of the entity.

39.52(16) The entity shall provide a description of the fees to be charged by the entity for independent reviews of a long-term care insurance benefit trigger decision.

39.52(17) The entity shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

39.52(18) The entity must have on staff or contract with a licensed health care practitioner who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

191—39.53(514G) Additional requirements. The independent review entity shall develop and maintain written policies and procedures governing all aspects of the independent review process. The written policies and procedures include, but are not limited to, the following:

39.53(1) Procedures to ensure that independent reviews are conducted within the time frames specified in this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, and that any required notices are provided in a timely manner.

39.53(2) Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the benefit trigger which is the subject of the benefit trigger decision under review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity) and be deemed experts in the assessment of such benefit trigger.

39.53(3) Procedures to ensure that the insured is notified in writing of the insured's right to object to the independent review entity selected by the insurer or to the licensed health care professional designated by the independent review entity to conduct the review by filing a notice of objection, along with the reasons for the objection, with the commissioner at the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319, within ten days of the receipt of a notice from the independent review entity.

39.53(4) Procedures to ensure the confidentiality of protected health information records and review materials, in accordance with federal and state law.

39.53(5) Procedures to ensure adherence to the requirements of this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, by any contractor, subcontractor, subvendor, agent or employee affiliated with the independent review entity.

39.53(6) Policies and procedures establishing a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in independent reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.

191—39.54(514G) Toll-free telephone number. The independent review entity shall establish a toll-free telephone service to receive information relating to independent reviews pursuant to this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to

respond to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.

191—39.55(514G) Insurance division application and reports. The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the independent review process established under Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694. An application for certification as an independent review entity must be submitted in duplicate to the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319. An application must be submitted in full to be considered. Every applicant will be notified of the certification decision. A list of certified independent review entities shall be maintained at the insurance division and shall be available through the division's Web site, www.iid.state.ia.us.

These rules are intended to implement Iowa Code section 514D.9 and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694.

[Filed 4/28/88, Notice 1/13/88—published 5/18/88, effective 7/1/88]
[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]
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[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07[1]]
[Filed emergency 12/12/07—published 1/2/08, effective 12/12/07]
[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 1/1/09◊]
[Filed emergency 12/24/08—published 1/14/09, effective 1/1/09]

◊ Two or more ARCs

1 Effective date of subrule 39.15(4) delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 2007.

APPENDIX A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF IOWA
FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____
_____
_____
_____

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX B

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year] [a one-time single premium of $_____].

Type of Policy (noncancellable/guaranteed renewable):_____

The Company's Right to Increase Premiums:_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?
□ From my Income □ From my Savings/Investments □ My Family will Pay
[□ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) □ Under $10,000 □ $[10-20,000] □ $[20-30,000] □ $[30-50,000] □ Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
□ No change □ Increase □ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) □ Yes □ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
□ From my Income □ From my Savings/Investments □ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost $_____for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
□ From my Income □ From my Savings/Investments □ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
□ Under $20,000 □ $20,000-$30,000 □ $30,000-$50,000 □ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
□ Stay about the same □ Increase □ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐	The answers to the questions above describe my financial situation. **Or**
☐	I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____ _____

(Applicant) (Date)

[□ I explained to the applicant the importance of completing this information.]

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a booklet called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

□ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

□ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of Iowa
For the Reporting Year of_____

Company Name: _____ Due: June 30 annually
Company Address: _____

_____

Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	**Nationwide Data**[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

[1]The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

[2] Example—home health care claim filed under a nursing home only policy.

[3]Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

[4] Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____].

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premiums.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Appendix G

Long-Term Care Insurance

Replacement and Lapse Reporting Form

For the State of_____ For the Reporting Year of_____

Company Name:_____ Due: June 30 annually

Company Address:_____ Company NAIC Number:_____

Contact Person:_____ Phone Number: (_____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced By This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed By This Agent	Number of Lapses As % of Number Sold By This Agent

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

CHAPTER 40
HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)
Appeared as Ch 12, July 1974 Supplement
[Prior to 10/22/86, Insurance Department [510]]

PREAMBLE

The following rules developed by the division of insurance govern the organization and regulation of health maintenance organizations pursuant to the authority set forth in Iowa Code chapter 514B.

191—40.1(514B) Definitions.

"Act" when used in these rules shall mean Iowa Code chapter 514B.

"Complaint" means a written communication expressing a grievance concerning a health maintenance organization.

"Dental care" means care by licensed dentists or by appropriate auxiliary dental personnel working under the supervision of a dentist. It includes the necessary diagnostic, treatment, and preventive services required to maintain proper oral health.

"Governing body" means the persons in which the ultimate responsibility and authority for the conduct of the HMO is vested.

"HMO" means health maintenance organization and shall be abbreviated as HMO in these rules.

"Inpatient hospital care" means inpatient hospital care provided through a licensed hospital on a 24-hour basis.

"Outpatient medical services" means outpatient medical services provided within or outside of a hospital. This shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

"Physician care" means care by a licensed physician or by paramedical or other ancillary health personnel under the direction of the licensed physician. It shall be of sufficient type and amount to adequately provide for the contracted services including emergency care, inpatient hospital care, and outpatient medical services.

191—40.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of $100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the health maintenance organization. The application with copies in duplicate shall be verified and shall be accompanied by the information found in Iowa Code section 514B.3(1 to 14). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner. See 40.11(514B).

An amendment to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

191—40.3(514B) Inspection of evidence of coverage. An enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the HMO within the ten-day period.

191—40.4(514B) Governing body and enrollee representation. An HMO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The HMO shall develop bylaws or guidelines which describe the scope of the health care services the HMO renders to enrollees either directly by its medical staff or dental staff, if dental care is provided, or

through arrangements with others outside of the organization. Initial bylaws, guidelines, and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The bylaws, guidelines, or similar document shall provide for "reasonable representation" on the governing body by enrollees. "Reasonable representation" as used in Iowa Code section 514B.7 shall require not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The HMO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the HMO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election.

The nomination procedures for enrollee representatives should provide for the following to assure an adequate opportunity for participation by enrollees:

40.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

40.4(2) Notice to all adult enrollees of the nomination and election procedures.

The HMO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives.

Nomination procedures may be waived by the commissioner for a period of up to three years from the HMO's commencement of delivery of services to enrollees.

For purposes of this rule, an HMO operated directly by a corporation or corporations subject to Iowa Code chapter 514 and rule 191—34.7(514) shall be deemed to be in compliance with this rule if it is or they are in compliance with Iowa Code section 514.4 and rule 191—34.7(514).

This rule is intended to implement Iowa Code section 514B.7.

191—40.5(514B) Quality of care. Each HMO shall:

40.5(1) Provide primary care physicians' services commensurate with the need of the enrollees, but at a level of not less than that established in the community.

40.5(2) Advise the insurance division annually pursuant to Iowa Code section 514B.12 of the ratio of full-time equivalent physicians, paramedical and ancillary health personnel to enrollees and fee-for-service patients. Changes in the physician ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

40.5(3) Provide assurance that all physicians, paramedical and ancillary health personnel engaged in the provisions of health services to enrollees and fee-for-service patients are currently licensed or certified by the appropriate state agency where they are located to practice their respective profession. These personnel shall be no less qualified in their respective profession than the current level of qualification, which is maintained in their community.

40.5(4) When health care facilities are utilized by the health maintenance organization, these facilities shall be licensed by the appropriate state agency where they are located. These facilities shall be either accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid.

40.5(5) Have a qualified administrator designated by the governing body who shall be responsible for the management of the HMO.

40.5(6) Have a formally organized medical staff.

40.5(7) Have a chief of the medical staff designated by the governing body who shall be responsible for the development of medical staff bylaws, rules which shall include assurance to enrollees that a continuum of health care services will be provided without unreasonable periods of delay.

40.5(8) Provide for an ongoing internal peer review program.

40.5(9) Each HMO shall provide a continuous program of general health education for disease prevention and identification without additional cost to the enrollee. Such a program may include publications, media presentations, and classroom instruction. Programs of wellness education including stress management, smoking cessation, nutritional education, physical fitness programs, and other such

programs as approved by the division of insurance shall be open to all enrollees on a voluntary basis and may be subject to a copayment requirement. These programs shall be conducted by qualified personnel.

The HMO must periodically remind and encourage the enrollees of an HMO to utilize benefits including physical examinations which are available and designed to prevent illness. The HMO must also offer periodic screening programs which in the opinion of the medical staff would effectively identify conditions indicative of a health problem. These periodic screening programs shall not carry a copayment. Each HMO shall keep a record of all activities it has conducted to satisfy this requirement and the cost thereof.

40.5(10) Maintain a medical records system which includes at a minimum the following information:

a. Documentation of utilization rates for every enrollee.

b. Patient's name, identification number, age, sex, and place of residence and employment.

c. Services provided, when provided, where provided, and by whom.

d. Medical diagnosis, treatment prescribed, therapy prescribed and drugs administered.

e. Statement in regard to the status of the patient's health.

40.5(11) Provide by contract or other arrangement for peer reviews. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the HMO staff on a continuing basis using Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or American Dental Association, if appropriate, standards as a general guide and shall be structured to review the total episode of illness that the HMO is responsible for. The HMO staff may use parts of the total episode of illness peer review done by other internal review committees to avoid duplication of work. This review shall include but not be limited to the following:

(1) Utilization review and evaluation of the quality of care provided enrollees.

(2) The process or method by which care is given.

(3) The outcome of care including the morbidity and mortality rates that result.

b. External review—criteria and methodology for the selection of an external review group (ERG):

(1) Application to be the ERG may be made in the form of a letter to the commissioner of insurance, describing the qualifications of the ERG and how the ERG meets the criteria set forth in this rule.

(2) Deleted per agency memo, 9/29/93 IAC.

(3) The commissioner shall invite an application from any ERG upon the request of any HMO.

(4) The commissioner may also invite applications from any group which might have the capability of carrying out a review.

(5) The commissioner will consider all applications and appoint one, based on the following criteria:

1. The group's experience in evaluating the quality of medical care.

2. The degree to which the group is representative of the licensed physician community in Iowa.

3. The degree to which the group is knowledgeable about the health delivery system in Iowa.

4. The degree to which selection of the group will avoid duplication with other review activities in Iowa.

5. The group's ability to coordinate its activities with other review groups, and with practitioners and providers of health care in Iowa.

6. The group's knowledge of current and accepted medical opinion, and its ability to make qualitative evaluations of clinical practice.

7. The degree to which at least 50 percent of the physician members of the group (or that part of the group responsible for HMO inspections) are members of an HMO medical staff.

(6) No physician shall review an HMO of which the physician is a member.

(7) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

c. External review—criteria and methodology by which an ERG will evaluate the effectiveness of an HMO's peer review program:

(1) The ERG will conduct an on-site inspection of each Iowa-certified HMO every two years, or on a schedule requested by the health department.

(2) The inspection will consist of interviewing HMO staff and physicians, and a review of such records (including clinical records of HMO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the HMO or any of its physician members which pertain to HMO quality assurance operations or HMO patients, excluding financial records.

(3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an HMO's internal peer review program, and to report its findings to the health department.

(4) The following items will be considered by the ERG in making its determination:

1. The extent and acuity of the HMO's peer review program in evaluating the clinical management of enrollees provided by HMO physicians.

2. The ability of the HMO's program to identify aberrant practices in clinical management, and to take appropriate disciplinary action.

3. The method within the HMO by which the peer review program reports its findings to the medical staff and the governing body.

4. The authority with the HMO to correct practices which the peer review program has found to be detrimental.

5. The system developed within the HMO to facilitate the work of the peer review program.

6. The commitment on the part of the HMO governing body and medical staff toward an active peer review program with a goal of quality assurance.

d. External review—procedures to be followed upon completion of an ERG's inspection:

(1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the HMO.

(2) The HMO will have 45 days to respond to the ERG.

(3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the HMO.

(4) The insurance division may extend the time periods referred to in this paragraph *"d,"* subparagraphs (1) to (3).

(5) After considering the report of the ERG, the insurance commissioner shall determine if the HMO's certificate of authority is to be either continued, suspended or revoked.

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

191—40.6(514B) Change of name. No name other than that certified by the division may be used. The name of the HMO may not be changed without prior approval of the division.

191—40.7(514B) Change of ownership. Each HMO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the HMO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—40.8(514B) Termination of services. When an HMO desires to cease offering a service, such service may not be terminated without prior approval of the division. Arrangements equitable to the enrollees providing for a rate adjustment or substitution of an equivalent service satisfactory to the division must be made.

191—40.9(514B) Complaints.

40.9(1) Each health maintenance organization shall provide in its bylaws for a system to resolve and record complaints.

40.9(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner:

a. Complaints about the quality of health care services provided by the health maintenance organization.

b. Complaints about the availability of such services.

c. Complaints relating to enrollee participation in the operation of the health maintenance organization.

40.9(3) The complaint system shall provide for the recording of the information required to be reported to the commissioner relative to the following kinds of complaints:

a. Complaints to the health maintenance organization concerning benefits provided by other than the health maintenance organization under the provisions of any indemnity policy or contract provided by the health maintenance organization. Such complaints shall be referred to the person providing the benefits and a copy shall be forwarded to the commissioner.

b. Malpractice claims settled during the year by the health maintenance organization and any of its providers.

40.9(4) The information required to be reported to the commissioner shall be included in the annual report to the commissioner on the form provided therewith.

40.9(5) All complaint files shall be retained by the health maintenance organization until the examination for the period during which the complaint was received has been completed.

191—40.10(514B) Cancellation of enrollees.

40.10(1) Membership of an enrollee in a health maintenance organization may be terminated by the health maintenance organization for the following reasons and no other:

a. Nonpayment of charges when due.

b. Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.

c. Termination of the group contract under which the enrollee was enrolled.

d. Change of place of residence of the enrollee from the geographic area served by the health maintenance organization.

e. Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(3).

f. Unreasonable refusal of the enrollee to follow a prescribed course of treatment.

g. A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.

40.10(2) When membership of an enrollee is terminated by the HMO for a reason other than nonpayment of charges, nonpayment of deductible or coinsurance charges, unreasonable refusal of the enrollee to accept services, or a materially false statement or misrepresentation by the enrollee in the application for membership, the HMO shall arrange to have offered to the enrollee an opportunity to have issued to the enrollee, at the expense of the enrollee, without evidence of insurability, individual or family policy or policies of hospital and medical expense insurance, or individual or family contracts with hospital and medical service corporations. The form of such policies or **c**ontracts shall be that shown in the Application for Certificate of Authority of the HMO or the latest approved amendment thereto. The conversion policy or contract shall provide coverage substantially similar to that provided by the HMO. The conversion policy or contract shall also provide at least $250,000 lifetime benefits. If the HMO enrolls persons on other than a group basis, it shall also offer to the enrollee, if the enrollment was canceled for the reason stated in 40.10(1)*"b*" or 40.10(1)*"c,"* an option to be enrolled as an individual enrollee. In the event of insolvency of an HMO and revocation of its certificate of authority, all other HMOs shall offer enrollees of the insolvent HMO an open enrollment period of 30 days after the date of revocation of the certificate.

40.10(3) Membership of an enrollee in a health maintenance organization may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

a. Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the health maintenance organization.

b. State the date and hour upon which the enrollment shall terminate.

c. State the reason for cancellation.

d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date the coverage will remain in force.

e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.

f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.

g. If the enrollee is entitled to have policies or contracts issued as provided in 40.10(2), it shall be stated how the enrollee may apply for such policies or contracts.

h. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, Lucas State Office Building, Des Moines, Iowa 50319.

40.10(4) When a hearing is requested, the commissioner may require the HMO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the HMO the charges for such period of coverage.

40.10(5) The hearing shall be held before the commissioner or the delegated hearing officer in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the health maintenance organization and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the health maintenance organization to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

This rule is intended to implement Iowa Code section 514B.17.

191—40.11(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY

_____

(Name of Health Maintenance Organization)

Organized as _____
under the laws of the state of _____, hereby makes application to the commissioner of insurance for a certificate of authority to establish and operate a health maintenance organization in compliance with Iowa Code chapter 514B.

Attached hereto and hereby made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

2. A copy of the bylaws, rules or similar document, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the health maintenance organization.

4. A copy of any contract made or to be made between any providers and the applicant.

4.1 A copy of any contract made or to be made between the applicant and any person listed in item (3).

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, his successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the HMO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance in consideration, when deemed appropriate, with the director of public health, under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workmen's compensation insurance to be maintained in force by the health maintenance organization.

15.1 Copies of the forms of policies or contracts to be offered to terminated enrollees as provided in 40.10(2).

VERIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;
(Name of Applicant)

that deponent is the _____ of such company,
(Title of Officer)

and that deponent is authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Subscribed and sworn to before me by _____on this _____ day of _____, 20 _____.

_____

(Notary Public)

191—40.12(514B) Net worth.

40.12(1) An HMO shall not be authorized to transact business with a net worth less than $1 million.

40.12(2) No HMO incorporated by or organized under the laws of any other state or government shall transact business in this state unless it possesses the net worth required of an HMO organized by the laws of this state and is authorized to do business in this state.

40.12(3) As deemed necessary by the division, each health maintenance organization that is a subsidiary of another person shall file with the division, in a form satisfactory to it, a guarantee of the HMO's obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

40.12(4) Each health maintenance organization shall, at the time of application, pay to the division a one-time, nonrefundable fee of $10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the solvency of an HMO.

191—40.13(514B) Fidelity bond. A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

This rule is intended to implement Iowa Code section 514B.5(1).

191—40.14(514B) Annual report. A health maintenance organization shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year.

The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for health maintenance organizations. The report shall be completed using "statutory accounting practices" (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from a health maintenance organization as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

This rule is intended to implement Iowa Code section 514B.12.

191—40.15(514B) Cash or asset management agreements. If an HMO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

40.15(1) Cash receipts shall be under the direct control of the HMO that generated the receipts. If the system is under the control of the HMO's parent or affiliate, then receipts shall be transferred to the HMO within five working days.

40.15(2) Securities purchased shall be in the name of the HMO generating the funds for the security purchase.

40.15(3) An HMO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the HMO. Such an agreement shall be subject to prior approval by the commissioner.

40.15(4) An HMO's cash or investments shall not be commingled with the cash or investments of any other person.

40.15(5) Investments made on behalf of an HMO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

40.15(6) The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

40.15(7) A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—40.16(514B) Deductibles and coinsurance charges. Rescinded IAB 10/15/03, effective 11/19/03.

191—40.17(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an HMO shall be subject to prior approval and shall meet the following minimum requirements:

40.17(1) Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

40.17(2) Retention levels shall be reasonable in light of the HMO's financial condition and potential liabilities.

191—40.18(514B) Provider contracts. An HMO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division within 30 days of execution for informational purposes. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between HMO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—40.19(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in a health maintenance organization, a producer must comply with the licensing rules set forth in 191—Chapter 10 of the Iowa Administrative Code and in particular

submit to an examination to determine the applicant's competence to sell accident and health insurance as described in rule 191—10.7(522), classification 6.

191—40.20(514B) Emergency services. Benefits shall be available by the HMO for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since HMOs may not contract with every emergency care provider in an area, HMOs shall make every effort to inform members of participating providers.

40.20(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

40.20(2) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

191—40.21(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in 191—40.1(514B), shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the HMO as outlined in rule 40.9(514B). Upon denial of reimbursement for emergency services, the HMO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—40.22(514B) Health maintenance organization requirements.

40.22(1) A health maintenance organization shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health maintenance organization's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health maintenance organization or a person contracting with the health maintenance organization.

40.22(2) A health maintenance organization shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health maintenance organization that, in the opinion of the provider, jeopardizes patient health or welfare.

191—40.23(514B) Disclosure requirements. All HMOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, an HMO offering a plan that includes a prescription drug formulary shall inform enrollees of the plan, and prospective enrollees of the plan during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All HMOs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—40.24(514B) Provider access. A health maintenance organization shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—40.25(514B) Electronic delivery of accident and health group insurance certificates.

40.25(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by health maintenance organizations and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 514B.9 and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

40.25(2) *Scope.* This rule shall apply to all health maintenance organizations holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 514B.

40.25(3) *Electronic delivery—health maintenance organizations.* The health maintenance organization will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The health maintenance organization takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the health maintenance organization furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

40.25(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 514B.

These rules are intended to implement Iowa Code chapter 514B and 1999 Iowa Acts, Senate File 276.

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CHAPTER 41
LIMITED SERVICE ORGANIZATIONS

191—41.1(514B) Definitions.

"Act" when used in these rules shall mean Iowa Code chapter 514B.

"Complaint" means a written communication expressing a grievance concerning a limited service organization.

"Governing body" means the persons in which the ultimate responsibility and authority for the conduct of the LSO is vested.

"Limited health services" include dental care services, vision care services, mental health services, behavioral health care services, substance abuse services, pharmaceutical services, podiatric care services, chiropractic services, nursing services, services of a licensed dietitian, physical therapy services, or any other category of services approved by the commissioner. "Limited health services" do not include employee assistance programs which provide only assessment and referral services or intermediate or long-term care facilities.

"Limited service organization (LSO)" means any corporation or limited liability company or other entity which, in return for prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Entities authorized to do business pursuant to Iowa Code chapters 508, 512B, 514, 514B (health maintenance organizations), 515, 520 and organized delivery systems shall not be required to obtain separate licensure as an LSO.

"Outpatient provider services" means outpatient provider services provided within or outside of a hospital. These services shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

"Producer" means a person engaged in solicitation or enrollment for an LSO and who ultimately delivers the certificate of membership or policy to a member.

"Provider" means any person or institution duly licensed or otherwise authorized to deliver or furnish limited health services.

191—41.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of $100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the LSO. The application with copies in duplicate shall be executed in conformance with rule 41.10(514B) and shall be accompanied by the information found in Iowa Code sections 514B.3(1) to 514B.3(14). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner, as indicated in rule 41.10(514B). Amendments to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

191—41.3(514B) Inspection of evidence of coverage. Except for groups which maintain a cafeteria plan pursuant to Section 125 of the Internal Revenue Code (28 U.S.C.A. § 125), an enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the LSO within the ten-day period. Enrollees in cafeteria plans must adhere to the plan provisions concerning termination or changes in coverage.

191—41.4(514B) Governing body and enrollee representation. An LSO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The LSO shall develop bylaws or guidelines which describe the scope of the health care services the LSO renders to enrollees directly by a provider. Initial articles of incorporation, bylaws, guidelines

of the LSO and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The articles of incorporation, bylaws, guidelines, or similar document shall provide for "reasonable representation" on the governing body by enrollees. "Reasonable representation" as used in Iowa Code section 514B.7 shall require that not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The LSO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the LSO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election. The nomination procedures for enrollee representatives should provide for the following to ensure an adequate opportunity for participation by enrollees:

41.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

41.4(2) Notice to all adult enrollees of the nomination and elective procedures. The LSO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives. Nomination procedures may be waived by the commissioner for a period of up to three years from the LSO's commencement of delivery of services to enrollees.

191—41.5(514B) Quality of care. Each LSO shall:

41.5(1) Advise the insurance division annually of the ratio of full-time providers and ancillary health personnel to enrollees to ensure an adequate network. Changes in the provider ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

41.5(2) Provide assurance that all personnel engaged in the provision of health services to enrollees are currently licensed or certified by the appropriate state agency where the providers are located to practice their respective professions. These personnel shall be no less qualified in their respective professions than the current level of qualification, which is maintained in the providers' communities.

41.5(3) Provide assurance that any health care facilities utilized by the LSO are licensed by the appropriate state agency where the facilities are located. These facilities shall be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid; or as otherwise accredited or licensed in accordance with state or federal law.

41.5(4) Have a qualified administrator designated by the governing body who shall be responsible for the management of the LSO.

41.5(5) Provide for an ongoing internal peer review program.

41.5(6) Maintain a provider records system which includes at a minimum the following information:

a. Documentation of utilization rates for every enrollee.

b. Patient's name, identification number, age, sex, and place of residence, and place of employment, if applicable.

c. Services provided, when provided, where provided, and by whom.

d. Provider diagnosis, treatment prescribed, therapy prescribed and drugs administered.

e. Statement in regard to the status of the patient's health, as appropriate.

41.5(7) Provide by contract or other arrangement for peer review. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the LSO staff on a continuing basis using standards adopted by the applicable accrediting body as a general guide. Internal peer review shall be structured to review the specific type of services for which the LSO is responsible. This review shall include but not be limited to the following:

(1) Utilization review and evaluation of the quality of services provided enrollees.

(2) The process or method by which services are provided.

(3) The outcome of services.

b. External review may be satisfied either by NCQA certification or meeting the requirements of the external review group appointed by the commissioner. The criteria and methodology for selection of an external review group (ERG) are as follows:

(1) The commissioner will appoint an ERG based on the following criteria:

1. The group's experience in evaluating the quality of service provided.

2. The degree to which the group is representative of the LSOs to be reviewed.

3. The degree to which the group is knowledgeable about the delivery of the services provided by the LSO in Iowa.

4. The group's ability to coordinate its activities with other review groups and with practitioners and providers of health services in Iowa.

5. The group's knowledge of current and accepted provider opinion and its ability to make qualitative evaluations of clinical practice.

(2) No provider shall review an LSO of which the provider is a member.

(3) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

c. The following are criteria and methodology by which an ERG will evaluate the effectiveness of an LSO's peer review program:

(1) The ERG will conduct an on-site inspection of each Iowa-certified LSO every two years.

(2) The inspection will consist of an interview with LSO staff and providers and a review of records (including clinical records of LSO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the LSO or any of its provider members which pertain to LSO quality assurance operations or LSO patients, excluding financial records.

(3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an LSO's internal peer review program and to report its findings to the insurance division.

(4) The following items will be considered by the ERG in making its determination:

1. The extent and acuity of the LSO's peer review program in evaluating the clinical management of enrollees provided by LSO providers.

2. The ability of the LSO's program to identify aberrant practices in clinical management and to take appropriate disciplinary action.

3. The method within the LSO by which the peer review program reports its findings to the provider staff and the governing body.

4. The authority within the LSO to correct practices which the peer review program has found to be detrimental.

5. The system developed within the LSO to facilitate the work of the peer review program.

6. The commitment on the part of the LSO governing body and provider staff toward an active peer review program with a goal of quality assurance.

d. The following are procedures to be followed upon completion of an ERG's inspection:

(1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the LSO.

(2) The LSO will have 45 days to respond to the ERG.

(3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the LSO.

(4) The insurance division may extend the time periods referred to in 41.5(7)*"d"*(1) to (3).

(5) After considering the report of the ERG, the insurance commissioner shall determine if the LSO's certificate of authority is to be continued, suspended or revoked.

191—41.6(514B) Change of name. No name other than that certified by the division may be used. The name of the LSO may not be changed without prior approval of the division.

191—41.7(514B) Change of ownership. Each LSO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the LSO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—41.8(514B) Complaints.

41.8(1) Each LSO shall provide in its bylaws for a system to resolve and record complaints.

41.8(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner.

a. Complaints about the quality of health care services provided by the LSO.

b. Complaints about the availability of such services.

c. Complaints relating to enrollee participation in the operation of the LSO.

41.8(3) The complaints record shall be included in the annual report to the commissioner.

41.8(4) All complaint files shall be retained by the LSO until the examination for the period during which the complaint was received has been completed.

191—41.9(514B) Cancellation of enrollees.

41.9(1) Membership of an enrollee in an LSO may be terminated by the LSO for the following reasons and no other:

a. Nonpayment of charges when due.

b. Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.

c. Termination of the group contract under which the enrollee was enrolled.

d. Change of place of residence of the enrollee from the geographic area served by the LSO.

e. Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(3).

f. Unreasonable refusal of the enrollee to follow a prescribed course of treatment.

g. A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.

h. Withdrawal of licensure by the LSO from the state. Upon withdrawal, an LSO has no obligation to secure replacement coverage for enrollees.

41.9(2) Membership of an enrollee in an LSO may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

a. Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the LSO.

b. State the date and hour upon which the enrollment shall terminate.

c. State the reason for cancellation.

d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date, the coverage will remain in force.

e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.

f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.

g. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, 330 E. Maple Street, Des Moines, Iowa 50319.

41.9(3) When a hearing is requested, the commissioner may require the LSO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the LSO the charges for such period of coverage.

41.9(4) The hearing shall be held before the commissioner or the delegated administrative law judge in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the LSO and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the LSO to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

191—41.10(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

LIMITED SERVICE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
(Name of Limited Service Organization)

Organized as _____ under the laws of the state of _____, makes application to the commissioner of insurance for a certificate of authority to establish and operate a limited service organization in compliance with Iowa Code chapter 514B.

Attached and made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document of the applicant, such as the articles of incorporation, articles of association or other applicable documents and all of its amendments.

2. A copy of the bylaws, rules or similar document regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the LSO.

4. A copy of any contract made or to be made between any providers and the applicant.

4.1 A copy of any contract made or to be made between the applicant and any person listed in paragraph "3" above.

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the LSO including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, the commissioner's successors in office and deputies as the true and lawful attorney of

the applicant for this state upon whom all lawful process in any legal action or proceeding against the LSO on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the LSO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workers' compensation insurance to be maintained in force by the LSO.

VERIFICATION

The undersigned deposes and states that deponent has duly executed the attached application dated _____, _____, for and on behalf of _____; that
(Year) (Name of Applicant)
the deponent is the _____ of such company, and that deponent is
(Title of Officer)
authorized to execute and file such instrument. Deponent further states that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature)

(type or print name beneath)

Subscribed and sworn to before me by _____on this _____ day of _____, _____.

(Year)

(Notary Public)

191—41.11(514B) Net equity and deposit requirements.

41.11(1) Net equity requirements.

a. Each LSO shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) $100,000 at the inception of the first year of operation, $200,000 at the inception of the second year of operation and thereafter; or

(2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

b. An LSO that has uncovered expenses in excess of $500,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of $500,000 in addition to the tangible net equity required by paragraph 41.11(1)*"a."*

c. For the purpose of this rule, "net equity" shall mean the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and "net equity" shall mean net equity reduced by the value assigned to intangible assets, including, but not limited to:

(1) Goodwill;

(2) Going-concern value;

(3) Organizational expense;

(4) Start-up costs;

(5) Obligations of officers, directors or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due;

(6) Long-term prepayments of deferred charges; and

(7) Nonreturnable deposits.

41.11(2) Deposits.

a. Each LSO shall deposit with the commissioner or with any organization or trustee meeting the requirements of rule 191—32.4(508) cash, securities or any combination of these that is acceptable to the commissioner having a fair market value equal to the minimum net worth of the LSO as determined by paragraph 41.11(1)*"a."* The amount on deposit shall remain as an admitted asset of the organization in the determination of its net worth.

b. All income from deposits shall be an asset of the LSO. An LSO may withdraw a deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these in an amount and value equal to that to be withdrawn. Securities shall be approved by the commissioner before being substituted.

41.11(3) No LSO organized under the laws of another state shall, directly or indirectly, assume risks or provide the services of an LSO, as defined in Iowa Code section 514B.33, subsection (3), unless it first obtains licensure from the commissioner and complies with the requirements of rule 191—41.11(514B).

41.11(4) As deemed necessary by the division, each LSO that is a subsidiary of another person shall file with the division, in a form satisfactory to the division, a guarantee of the LSO's obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

41.11(5) Each LSO shall, at the time of application, pay to the division a one-time, nonrefundable fee of $10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the insolvency of an LSO.

191—41.12(514B) Fidelity bond. An LSO shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

191—41.13(514B) Annual report. An LSO shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year. The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for LSOs. The report shall be completed using statutory accounting practices (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from an LSO as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

191—41.14(514B) Cash or asset management agreements. If an LSO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

1. Cash receipts shall be under the direct control of the LSO that generated the receipts. If the system is under the control of the LSO's parent or affiliate, then receipts shall be transferred to the LSO within five working days.

2. Securities purchased shall be in the name of the LSO generating the funds for the security purchase.

3. An LSO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the LSO. Such an agreement shall be subject to prior approval by the commissioner.

4. An LSO's cash or investments shall not be commingled with the cash or investments of any other person.

5. Investments made on behalf of an LSO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

6. The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

7. A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—41.15(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an LSO shall be subject to prior approval and shall meet the following minimum requirements:

1. Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

2. Retention levels shall be reasonable in light of the LSO's financial condition and potential liabilities.

191—41.16(514B) Provider contracts. An LSO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division for approval. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to, nonpayment by the LSO, LSO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the LSO acting on the providers' behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on LSO's behalf made in accordance with terms of (applicable agreement) between LSO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the LSO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—41.17(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in an LSO, a producer must comply with the licensing rules set forth in 191—Chapter 10 of the Iowa Administrative Code and in particular submit to an examination to determine the applicant's competence to sell accident and health insurance as described in rule 191—10.7(522), qualification 6.

191—41.18(514B) Emergency services. "Emergency services" (inpatient and outpatient), as defined in rule 191—40.20(514B), shall be provided by the LSO, either through its own facilities or through guaranteed arrangements with other providers, on a 24-hour basis unless a waiver from such services is approved by the commissioner. A provider and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since LSOs may not contract with every emergency care provider in an area, LSOs shall make every effort to inform members of participating providers.

191—41.19(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in rule 191— 40.20(514B), shall not be denied by any LSO without that organization's review of the patient's provider history, presenting symptoms, and admitting or initial as well as final diagnosis,

submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the LSO as outlined in rule 191—40.9(514B). Upon denial of reimbursement for emergency services, the LSO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—41.20(514B) Limited service organization requirements. An LSO shall not prohibit or otherwise restrict a participating provider from advising a covered person about the health status of the covered person or medical care or treatment of the covered person's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the provider is acting within the lawful scope of practice.

An LSO shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the LSO that, in the opinion of the provider, jeopardizes patient health or welfare.

191—41.21(514B) Disclosure requirements. All LSOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all LSOs offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All LSOs shall also disclose the existence of any contractual arrangements providing rebates received by them for drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated uses and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily function or preventing further deterioration of the medical condition caused by sickness or injury.

These rules are intended to implement Iowa Code section 514B.33.

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CHAPTER 42
GENDER-BLENDED MINIMUM NONFORFEITURE STANDARDS FOR LIFE INSURANCE

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

191—42.1(508) Purpose. The purpose of this rule is to permit life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this rule.

191—42.2(508) Definitions. For purposes of this chapter, the following definitions shall apply:

"1980 CSO Table, with or without Ten-Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors.

"1980 CSO Table (M), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table with or without Ten-Year Select Mortality Factors.

"1980 CSO Table (F), with or without Ten-Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

"1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

"1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

"1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

191—42.3(508) Use of gender-blended mortality tables. For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of Iowa Code section 508.37, an insurer may:

42.3(1) Substitute a mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without Ten-Year Select Mortality Factors for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture values, and

42.3(2) Substitute a mortality table which is of the same blend as used in subrule 42.3(1) above but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) for the 1980 CET Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

42.3(3) The following tables, as developed and revised by the Society of Actuaries and adopted by the National Association of Insurance Commissioners shall be considered as the basis for acceptable gender-blended mortality tables:

a. 100 percent male 0 percent female, for tables to be designated as the "1980 CSO-A" and "1980 CET-A" tables.

b. 80 percent male 20 percent female, for tables to be designated as the "1980 CSO-B" and "1980 CET-B" tables.

c. 60 percent male 40 percent female, for tables to be designated as the "1980 CSO-C" and "1980 CET-C" tables.

d. 50 percent male 50 percent female, for tables to be designated as the "1980 CSO-D" and "1980 CET-D" tables.

e. 40 percent male 60 percent female, for tables to be designated as the "1980 CSO-E" and "1980 CET-E" tables.

f. 20 percent male 80 percent female, for tables to be designated as the "1980 CSO-F" and "1980 CET-F" tables.

g. 0 percent male 100 percent female, for tables to be designated as the "1980 CSO-G" and "1980 CET-G" tables.

Tables 1980 CSO-A, 1980 CET-A, 1980 CSO-G, and 1980 CET-G shall not be used with respect to policies issued on or after January 1, 1985, except where 90 percent or more of persons insured thereunder are anticipated to be of one gender or except for certain policies converted from group insurance. Such group conversions issued on or after January 1, 1986, shall use mortality tables based on the blend of lives by gender expected for such policies if the group conversion policy is considered to be controlled by the decision in *Arizona Governing Committee v. Norris.*

191—42.4(508) Unfair discrimination. It shall not be a violation of Iowa Code section 507B.4(7) for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

191—42.5(508) Separability. If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected.

191—42.6(508) 2001 CSO Mortality Table. The 2001 CSO Mortality Table shall be used for purposes of this chapter pursuant to the requirements of 191—Chapter 91.

These rules are intended to implement Iowa Code section 508.37(6)*"h"*(6).

[Filed 6/15/84, Notice 3/14/84—published 7/4/84, effective 8/8/84]
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CHAPTER 43
ANNUITY MORTALITY TABLES FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

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

191—43.1(508) Purpose. The purpose of this chapter is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: the 1983 Table "a" and 1983 Group Annuity Mortality (1983 GAM) Table, the Annuity 2000 Mortality Table, and the 1994 Group Annuity Reserving (1994 GAR) Table.

191—43.2(508) Definitions. For purposes of this chapter, the following definitions shall apply:

"1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners.

"1983 Table 'a'" means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners.

"1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866 and 867 of Volume XLVII of the Transactions of the Society of Actuaries (1995). The 1994 GAR Table was adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners.

"Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the Transactions of the Society of Actuaries (1995). The Annuity 2000 Mortality Table was adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners.

191—43.3(508) Individual annuity or pure endowment contracts.

43.3(1) Except as provided in subrules 43.3(2) and 43.3(3), the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1980.

43.3(2) Except as provided in subrule 43.3(3), either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after December 30, 1985.

43.3(3) Except as provided in subrule 43.3(4), the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2000.

43.3(4) The 1983 Table "a" without projection is to be used for determining the minimum standard of valuation for an individual annuity or pure endowment contract issued on or after January 1, 2000, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. Settlements of various forms of claims pertaining to court settlements or out-of-court settlements from tort actions;
2. Settlements involving similar actions such as workers' compensation claims; or
3. Settlements of long-term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

191—43.4(508) Group annuity or pure endowment contracts.

43.4(1) Except as provided in subrules 43.4(2) and 43.4(3), the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one table may be used for purposes of valuation for any annuity or pure endowment purchased on or after January 1, 1980, under a group annuity or pure endowment contract.

43.4(2) Except as provided in subrule 43.4(3), either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after December 30, 1985, under a group annuity or pure endowment contract.

43.4(3) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 2000, under a group annuity or pure endowment contract.

191—43.5(508) Application of the 1994 GAR Table. In using the 1994 GAR Table, the mortality rate for a person aged x in year (1994 + n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} and AA_xs are as specified in the 1994 GAR Table.

191—43.6(508) Separability. If any provision of this rule or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code sections 508.36(3)*"a"*(1) and 508.36(3)*"a"*(3)(c).

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CHAPTER 44
SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

191—44.1(508) Purpose. The purpose of the rule is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate risk classifications for smokers and nonsmokers.

191—44.2(508) Definitions.

"1980 CSO Table, with or without Ten-Year Select Mortality Factor" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

"1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

"1958 CSO Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

"1958 CET Table" means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Extended Term Insurance Table.

"Smoker and nonsmoker mortality tables" means those mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in the first four paragraphs of this rule which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance Department staff and recommended by the NAIC Technical Staff Actuarial Group.

"Composite mortality tables" means those mortality tables defined in the first four paragraphs of this rule as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

191—44.3(508) Alternate tables.

44.3(1) In determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this state after the operative date of Iowa Code section 508.37(6)*"k"* for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in rule 44.4(508):

a. The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

b. The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

For any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according

to an age not more than six years younger than the actual age of the insured. Further, the substitution of the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

44.3(2) In determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this state after the operative date of Iowa Code section 508.37(6)*"k"* for that policy form, at the option of the company and subject to the conditions stated in rule 44.4(508):

a. The 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

b. The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

191—44.4(508) Conditions. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may:

1. Use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits,

2. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Iowa Code section 508.36(3)*"a"*(1) and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or

3. Use smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

191—44.5(508) Separability. If any provision of this chapter or the application of this chapter to any person or circumstance is for any reason held to be invalid, the remainder of this chapter and the application of the remaining provisions to other persons or circumstances shall not be affected.

191—44.6(508) 2001 CSO Mortality Table. The 2001 CSO Mortality Table shall be used for purposes of this chapter pursuant to the requirements of 191—Chapter 91.

These rules are intended to implement Iowa Code section 508.37(6)*"h"*(6).

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INSURANCE HOLDING COMPANY SYSTEMS

CHAPTER 45
INSURANCE HOLDING COMPANY SYSTEMS

[Appeared as Ch 11, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

191—45.1(521A) Purpose. The purpose of these rules is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of Iowa Code chapter 521A. The information called for by these rules is hereby declared to be necessary and appropriate in the public interest and for the protection of policyholders in this state.

This rule is intended to implement Iowa Code section 521A.8.

191—45.2(521A) Definitions. As used in these rules unless otherwise required by the context:

45.2(1) *"Executive officer"* means any individual charged with active management and control in an executive capacity (including a president, vice-president, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers) of a person, whether incorporated or unincorporated.

45.2(2) *"Foreign insurer"* shall include an alien insurer except where clearly noted otherwise.

45.2(3) *"Ultimate controlling person"* means that person who is not controlled by any other person.

45.2(4) Other terms found in these rules and in Iowa Code section 521A.1 entitled "Definitions" shall retain the meaning as found in such section.

191—45.3(521A) Subsidiaries of domestic insurers. The authority to invest in subsidiaries under Iowa Code section 521A.2(3) is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the insurance code.

An investment by a subsidiary under Iowa Code section 521A.2(3)*"c"* may cause the total investment of the insurer to exceed any of the limitations contained in any of the individual Iowa Code provisions referred to in section 521A.2(3)*"c"* provided that it does not exceed the aggregate amount which could be invested under all of those provisions with respect to the type of asset involved.

191—45.4(521A) Control acquisition of domestic insurer. Any person required to file a statement pursuant to Iowa Code section 521A.3 entitled "Acquisition of control of or merger with domestic insurer," shall furnish all the information requested on FORM A hereto annexed and hereby made a part of these rules.

45.4(1) If the person being acquired is a "domestic insurer" solely because of the provisions of Iowa Code section 521A.3(1), the name of the domestic insurer on the cover page should be as follows: "ABC Insurance Company, a Subsidiary of XYZ Holding Company."

45.4(2) Where a domestic insurer, including any other person controlling a domestic insurer, unless such other person is either directly or through its affiliate primarily engaged in business other than the business of insurance is being acquired, references to "the insurer" contained in FORM A shall refer to both the domestic subsidiary insurer and the person being acquired.

45.4(3) The applicant shall promptly advise the commissioner of any changes in the information so furnished arising subsequent to the date upon which such information was furnished but prior to the commissioner's disposition of the application.

45.4(4) Exemptions. No statement need be filed and no approval by the commissioner is required pursuant to Iowa Code section 521A.3 if the company being acquired is considered a domestic insurer solely by reason of Iowa Code section 521A.3(1) and provided such acquisition is subject to disclosure requirements in said company's state of domicile substantially similar to those imposed by Iowa Code section 521A.3.

191—45.5(521A) Registration of insurers. Any insured required to file an annual registration statement pursuant to Iowa Code section 521A.4 shall furnish all the information required on FORM B hereto annexed and hereby made a part of these rules.

An insurer required to file an annual registration statement pursuant to Iowa Code section 521A.4 is also required to furnish information required on FORM C, hereby made a part of these regulations. An insurer shall file a copy of FORM C in each state in which the insurer is authorized to do business, if requested by the commissioner of that state.

191—45.6(521A) Alternative and consolidated registrations. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under section 521A.4. A registration statement may include information regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on FORM B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

1. The statement or report contains substantially similar information required to be furnished on FORM B; and
2. The filing insurer is the principal insurance company in the insurance holding company system.

45.6(1) The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of FORM B on behalf of an affiliated insurer shall set forth a simple statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

45.6(2) With the prior approval of the commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subrule 45.6(1).

Any insurer may take advantage of the provisions of Iowa Code section 521A.4(7) or 521A.4(8) without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if the commissioner deems such filings necessary in the interest of clarity, ease of administration or the public good.

191—45.7(521A) Exemptions. A foreign or alien insurer otherwise subject to Iowa Code section 521A.4, shall not be required to register pursuant to that section if it is admitted in the domiciliary state of the principal insurer (as that term is defined in 45.6(1)) and in said state if subject to disclosure requirements and standards adopted by the statute or rules which are substantially the same as those contained in Iowa Code section 521A.4, provided, the commissioner may require a copy of the registration statement or other information filed with the domiciliary state.

45.7(1) The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purposes of these rules.

45.7(2) Any insurer not otherwise exempt or excepted from Iowa Code section 521A.4 may apply for an exemption from the requirements of said section by submitting a statement to the commissioner setting forth its reasons for being exempt.

191—45.8(521A) Disclaimers and termination of registration. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

45.8(1) The number of authorized, issued and outstanding voting securities of the subject;

45.8(2) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

45.8(3) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

45.8(4) A statement explaining why such person should not be considered to control the subject.

A request for termination of registration shall be deemed to have been granted unless the commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

191—45.9(521A) Transactions subject to prior notice—notice filing. An insurer required to give notice of a proposed transaction pursuant to Iowa Code section 521A.5 shall furnish the required information on FORM D, hereby made a part of these regulations.

191—45.10(521A) Extraordinary dividends and other distributions. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

45.10(1) The date established for payment of the dividend;

45.10(2) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof of its cost, and its fair market value together with an explanation of the basis for valuation;

45.10(3) The amounts and dates of all dividends (including regular dividends) paid within the period of 24 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the second and immediately preceding years;

45.10(4) A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted;

45.10(5) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

45.10(6) A dividend or distribution to an insurer's shareholders which exceeds the greater of (a) 10 percent of the insurer's surplus as regards policyholders as of the 31st day of December next preceding, or (b) the net gain from operations of such insurer if the insurer is a life insurer, or the net income if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the 31st day of December next preceding must be submitted to the commissioner 30 days in advance for approval. The commissioner may deem such dividend to be excessive and constitute grounds under 191—subrule 5.23(6) for finding the insurer to be in a financially hazardous condition and subject to the provisions of 191—subrule 5.24(2).

FORM A

STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____

Name of Domestic Insurer
BY

_____

Name of Acquiring Person (Applicant)
Filed with the Insurance Division of Iowa

Dated: _____, 20 _____
Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____

_____

_____

_____

FORM A

Item 1. Insurer and method of acquisition.

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

Item 2. Identity and background of the applicant.

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than one-half of one percent of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

Item 3. Identity and background of individuals associated with the applicant.

State the following with respect to (1) the applicant if an individual or (2) all persons who are directors, executive officers or owners of 10 percent or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices or employments during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

Item 4. Nature, source and amount of consideration.

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity to remain confidential, the applicant must specifically request that the identity be kept confidential.

Item 5. Future plans for insurer.

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

Item 6. Voting securities to be acquired.

State number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

Item 7. Ownership of voting securities.

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

Item 8. Contracts, arrangements or understandings with respect to voting securities of the insurer.

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any persons listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

Item 9. Recent purchases of voting securities.

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

Item 10. Recent recommendations to purchase.

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

Item 11. Agreements with broker-dealers.

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealer, with regard thereto.

Item 12. Financial statements and exhibits.

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2*(c)* for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto; any proposed employment, consultation, advisory or management contracts concerning the insurer; annual reports to the stockholders of the insurer and the

applicant for the last two fiscal years; and any additional documents or papers required by Form A or regulations sections 0.04 and 0.06.

Item 13. Signature and certification. Signature and certification of the following form:

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.3 and Regulation 3.01, _____ has caused this application to be duly signed on its
(Name of Applicant)
behalf in the City of _____ and State of _____, on the _____ day of _____, 20 _____.

(SEAL)

_____
(Name of Applicant)

By _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;
(Name of Applicant)
that deponent is the _____ of such company, and that deponent is authorized to
(Title of Officer)
execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of the deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

FORM B

INSURANCE HOLDING COMPANY SYSTEM
ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Division of Iowa

By

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

Date: _____, 20 _____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

FORM B

Item 1. Identity and control of registrant.

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.

Item 2. Organizational chart.

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are equal to less than one-half of 1 percent of the total assets of the ultimate controlling person within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

Item 3. The ultimate controlling person.

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

(e) The principal business of the person.

(f) The name and address of any person who holds or owns 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

Item 4. Biographical information.

Furnish the following information for the directors and executive officers of the ultimate controlling person: The individual's name, address, principal occupation and all offices and positions held during

the past five years; and any conviction of crimes other than minor traffic violations during the past ten years.

Item 5. Transactions, relationships and agreements.

(a) Briefly describe the following agreements in force, relationships subsisting, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) Purchases, sales or exchanges of assets;

(3) Transactions not in the ordinary course of business;

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles;

(6) Reinsurance agreements;

(7) Dividends and other distributions to shareholders; and

(8) A pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate, for a loan made to a member of the insurance holding company system.

No information need be disclosed if such information is not material. Sales, purchases, exchanges, loans or extensions of credit or investments involving one-half of 1 percent or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: the nature and purpose of the transaction; the nature and amounts of any payments or transfers of assets between the parties; the identity of all parties to such transaction; and relationship of the affiliated parties to the Registrant.

Item 6. Litigation or administrative proceedings.

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

Item 7. Financial statements and exhibits.

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is

an insurer who is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by FORM B requested by the commissioner.

SIGNATURES

Signatures and certification of the form as follows:

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.4 and Regulation No. 4.01, the Registrant has caused this registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

(SEAL)

_____
(Name of Registrant)

By _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;
(Name of Company)

that deponent is the _____ of such company, and that deponent is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of the deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

FORM C
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Division of Iowa

By

_____
Name of Registrant

On Behalf of the following insurance companies

Name Address

Date: _____, 20 _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this summary should be addressed:

Furnish a brief description of all items in the current annual registration statement which represented changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include specific references to item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of FORM B, insofar as changes in the percentage of each class of voting securities held by each affiliate are concerned, need be included only where such changes are ones which result in ownership or holdings of 10 percent or more of voting securities, loss or transfer of control, or acquisition of loss of partnership interest.

Changes occurring under Item 4 of FORM B need be included only where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates their responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and describe any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.4, the registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

_____
(Name of Registrant)

_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

(SEAL)

CERTIFICATION

The undersigned deposes and says that having duly executed the attached summary of registration statement dated _____, 20 _____, for and on behalf of _____; as _____ of such company, with
(Name of Company) (Title of Officer)
authority to execute and file such instrument, deponent is familiar with such instrument and the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Division of Iowa

By

_____
Name of insurer filing notice

On behalf of the following insurance companies

Name Address

_____

_____

_____

Date: _____, 20 _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this summary should be addressed:

_____

_____

Item 1. Identity of parties to transaction.

Furnish the following information for each of the parties to the transaction:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, i.e., corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a nonaffiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

Item 2. Description of the transaction.

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under Iowa Code section 521A.5(1)*"b"* or section 521A.5(1)*"c."*

(b) A statement of the nature of the transaction.

(c) The proposed effective date of the transaction.

Item 3. Sales, purchases, exchanges, loans, extensions of credit, guarantees, or investments.

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice; a description of the terms of any securities being received, if any; and a description of any other agreements relating to the transaction such as contracts, agreements for services, or consulting agreements. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the sale, purchase, exchange, loan, extension of credit, guarantee or investment is one which is less than the greater of 5 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders.

Item 4. Reinsurance.

If the transaction is a reinsurance agreement or modification thereto, furnish a description of the known or estimated amount of liability to be ceded or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement of whether an agreement will be in effect, and a statement of whether an agreement or understanding exists between the insurer and a nonaffiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modification thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 25 percent of the insurer's surplus as regards policyholders, as of the preceding 31st day of December.

Item 5. Management agreements, service agreements and cost-sharing agreements.

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities or services to be performed; and

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement;

(b) A description of the period of time during which the agreement is to be in effect;

(c) A brief description of each party's expenses or costs covered by the agreement; and

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

Pursuant to the requirements of Iowa Code section 521A.5, the applicant has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

_____
(Name of requesting party)

By: _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

(SEAL)

_____
(Title)

CERTIFICATION

The undersigned acknowledges that having duly executed the attached prior notice of a transaction dated _____, 20 _____, for and on behalf of _____;
(Name of Company)

as _____ of such company, with authority to execute and file such instrument,
(Title of Officer)

deponent is familiar with such instrument and the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

These rules are intended to implement Iowa Code sections 521A.4 and 521A.8.

[Filed 11/19/70; amended 12/14/72]
[Filed 2/23/83, Notice 1/19/83—published 3/16/83, effective 4/20/83]
[Filed 8/21/86, Notice 7/16/86—published 9/10/86, effective 10/15/86]
[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed emergency 6/21/91—published 7/10/91, effective 6/21/91]
[Filed 3/5/99, Notice 11/4/98—published 3/24/99, effective 4/28/99]

CHAPTER 46
MUTUAL HOLDING COMPANIES

191—46.1(521A) Purpose. This chapter is intended to implement the provisions of Iowa Code Supplement section 521A.14 as amended by 1996 Iowa Acts, House File 2363, to provide for:

46.1(1) The formation of a mutual insurance holding company through an application process subject to regulation by the division of insurance. A domestic mutual insurance company may reorganize by forming a mutual insurance holding company based upon a mutual plan. The reorganized insurance company shall continue, without interruption, its corporate existence as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is subsidiary to the mutual insurance holding company.

46.1(2) The reorganization of a domestic mutual insurance company by merging its policyholders' membership interests into a mutual insurance holding company and continuing, without interruption, the corporate existence of the reorganized insurance company as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is a subsidiary to the mutual insurance holding company through an application process subject to regulation by the division of insurance.

46.1(3) An application process for the approval of an initial sale of the shares of the capital stock of a reorganized domestic insurance company or an intermediate holding company, subject to the approval of the division of insurance.

191—46.2(521A) Definitions. As used in this chapter:

"Affiliated person" of another person means:

1. Any person directly or indirectly owning, controlling, or holding with power to vote, 5 percent or more of the outstanding voting securities of such other person,
2. Any person 5 percent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person,
3. Any person directly or indirectly controlling, controlled by, or under common control with, such other person, or
4. Any officer, director, partner, copartner, or employee of such other person.

"Commissioner" means the Iowa commissioner of insurance.

"Division" means the Iowa insurance division.

"Domestic mutual insurance company" means an insurance company organized on a mutual plan and incorporated under the laws of Iowa.

"Interested person" of another person means:

1. Any affiliated person of such company,
2. Any member of the immediate family of any natural person who is an affiliated person of such company,
3. Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as legal counsel for such company, or
4. Any natural person whom the commissioner by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company.

"Intermediate holding company" means a holding company which is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company pursuant to the provisions of Iowa Code chapter 521A.

"Limited application" means an application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, 100 percent of the stock of its insurance subsidiaries.

"Member of the immediate family" means any parent, spouse of a parent, child, spouse of a child, spouse, brother or sister, and includes step and adoptive relationships.

"Mutual insurance holding company" means a holding company organized on a mutual plan and incorporated under the laws of Iowa, resulting from the reorganization of a domestic mutual insurance company pursuant to the provisions of Iowa Code section 521A.14, with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries. A mutual insurance holding company shall be a person as defined in section 521A.1(7) and shall be subject to the provisions of Iowa Code chapter 521A.

"Plan of reorganization" means a plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company.

"Section 521A.14" means section 44 of House File 247 as enacted by the 1995 session of the 76th General Assembly.

"Standard application" means an application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

"Stock" means any security evidencing an equity interest in the issuing entity.

"Stock offering" means any proposed sale, exchange, transfer or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of these rules, "stock offering" shall not mean (1) an offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights or (2) a transfer of stock between any of the following:

- A mutual insurance holding company,
- An insurance company subsidiary of a mutual insurance holding company,
- An intermediate holding company subsidiary of a mutual insurance holding company, and
- An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company.

191—46.3(521A) Application—contents—process.

46.3(1) An application shall be designated as either:

a. A limited application, or

b. A standard application.

The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in rule 46.9(521A).

46.3(2) The application shall be filed in triplicate with the commissioner and shall include the following information:

a. Designation as a limited or standard application.

b. A plan of reorganization as set forth in 46.4(521A).

c. A plan to obtain the approval of the policyholders in accordance with the applicant's articles of incorporation and bylaws. Policyholders shall be given not less than 20 days' notice of any vote on approval of reorganization.

d. A copy of the mutual insurance holding company's proposed articles of incorporation and bylaws specifying all membership rights.

e. The names, addresses and occupational information of all corporate officers and members of the initial mutual insurance holding company board of directors.

f. Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization.

g. A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary.

h. A "Form A" filing as described in 191—Chapter 45, Iowa Administrative Code.

i. An index demonstrating where in the application information supplied in compliance with each of these rules is found.

j. Any other information requested by the commissioner at any time during the course of proceedings.

46.3(3) Upon receipt and review by the commissioner of all information provided pursuant to 46.3(2), a hearing shall be held as provided in Iowa Code section 521A.3, subsection 4, paragraph *"b."* The applicant shall present evidence establishing:

a. The application is in compliance with all pertinent Iowa Code sections and administrative rules; and

b. The requirements for a plan of reorganization have been fulfilled.

Notice of the hearing shall be given at least 20 days prior to the hearing by the insurance division by regular mail to all interested parties known to the division.

191—46.4(521A) Plan of reorganization.

46.4(1) A limited application plan of reorganization shall include provisions:

a. Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the mutual insurance holding company.

b. Protecting the interests of existing policyholders.

c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

d. Describing a plan providing for membership interests of future policyholders.

e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

f. Demonstrating that, in the event of proceedings under Iowa Code chapter 507C involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

g. Describing a plan how any accumulation or prospective accumulation of earnings by the mutual insurance holding company which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

h. Describing the nature and content of the annual report and financial statement to be sent to each member.

i. For other matters, as the applicant deems appropriate.

46.4(2) A standard application plan of reorganization shall include provisions:

a. Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one wholly owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company.

b. Protecting the interests of existing policyholders.

c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.

d. Providing for membership interests of future policyholders.

e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.

f. Demonstrating that, in the event of proceedings under Iowa Code chapter 507C involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.

g. Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company, which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary, shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

h. Describing the nature and content of the annual report and financial statement to be sent to each member.

i. Describing the applicant's plan for a stock offering in accordance with the provisions of rule 46.109(521A) below.

j. Describing other relevant matters the applicant deems appropriate.

46.4(3) With regard to either a limited or standard application, the plan of reorganization submitted to the commissioner shall demonstrate:

a. Policyholder interests are properly preserved and protected.

b. The plan is fair and equitable to policyholders.

c. The financial condition of the applicant will not be diminished.

191—46.5(521A) Duties of the commissioner.

46.5(1) The commissioner shall at all times retain jurisdiction over the mutual insurance holding company and its intermediate holding company subsidiaries with stock insurance company subsidiaries.

46.5(2) Following the hearing provided in 46.3(3) the commissioner shall, by order, approve, conditionally approve, or deny an application. The commissioner may require, as a condition of approval of the proposed reorganization, such modifications of the proposed plan of reorganization as the commissioner finds necessary. The applicant shall accept such required modifications by filing appropriate amendments to the proposed plan of reorganization with the commissioner within 30 days of the date of the order of the commissioner requiring such modifications. If the applicant does not accept such required modifications by failing to file the required amendments to the proposed plan of reorganization within 30 days, the proposed reorganization shall be deemed denied.

46.5(3) An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within 180 days unless such time period is extended by the commissioner upon a showing of good cause.

46.5(4) The commissioner may revoke approval or conditional approval of an applicant's plan of reorganization in the event the commissioner finds the applicant has failed to comply with the plan of reorganization. The commissioner may compel completion of a plan of reorganization pursuant to Iowa Code section 521A.9 unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance. The commissioner shall retain jurisdiction over the applicant until a plan of reorganization has been completed.

46.5(5) Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the commissioner.

191—46.6(521A) Regulation—compliance.

46.6(1) Mutual insurance holding companies shall comply with the provisions of Iowa Code chapter 521A except as expressly provided herein.

46.6(2) No regulatory standards are waived during the pendency of an application for a plan of reorganization.

46.6(3) Mergers and acquisitions by a mutual insurance holding company must be approved by the commissioner pursuant to Iowa Code chapters 521 and 521A. At such time as a mutual insurance holding company acquires or plans to acquire more than 50 percent of a stock insurance company, the mutual insurance holding company shall submit to the commissioner a plan describing any membership interests of policyholders.

46.6(4) Each mutual insurance holding company shall supply to the insurance division, by April 1 of each year, an annual statement consisting of the following:

a. An income statement.

b. A balance sheet.

c. A cash flow statement.

d. Complete information on the status of any closed block formed as a part of a plan of reorganization.

e. An investment plan covering all assets.

f. A statement disclosing any intention to pledge, borrow against, alienate, hypothecate or in any way encumber the assets of the mutual insurance holding company.

46.6(5) At least 50 percent of the generally accepted accounting practices (GAAP) net worth of a mutual insurance holding company shall be invested in insurance company subsidiaries.

46.6(6) No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend or other distribution unless such payment has been approved by the commissioner. The commissioner, after a public hearing as provided in Iowa Code section 521A.3(4)*"b,"* if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of such approval modification of the proposed payment as the commissioner finds necessary for the protection of such policyholders.

191—46.7(521A) Reorganization of domestic mutual insurer with mutual insurance holding company. A domestic mutual insurance company may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the commissioner a joint application with the mutual insurance holding company complying with the provisions of 46.3(521A).

191—46.8(521A) Reorganization of foreign mutual insurer with mutual insurance holding company. A foreign mutual insurance company, or a foreign health service corporation, which if a domestic corporation would be organized under Iowa Code chapter 514, may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the commissioner a joint application with the mutual insurance holding company complying with the provisions of 46.3(521A).

191—46.9(521A) Mergers of mutual insurance holding companies. A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the commissioner a plan of merger and complying with the provisions of Iowa Code chapters 521 and 521A.

191—46.10(521A) Stock offerings.

46.10(1) No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the commissioner. The commissioner's approval may be obtained only through the application and hearing process described below.

46.10(2) Every application for approval of a stock offering shall contain the following information:

a. A description of the stock intended to be offered by the applicant, including a description of all shareholder rights.

b. The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer.

c. A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined.

d. The name or names of any underwriter, syndicate member or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control 5 percent of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application.

e. A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering.

f. A detailed description of all expenses to be incurred in conjunction with the stock offering.

g. An explanation of how funds raised by the stock offering are to be used.

h. Any other information requested by the commissioner.

46.10(3) No application regarding a planned stock offering shall be approved unless the plan contains provisions:

a. Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors and insiders, for a period of at least six months following the first date the offering was publicly and regularly traded. This paragraph shall not be construed to limit the rights of officers, directors and insiders from exercising subscription rights generally accorded members of the mutual insurance holding company, except that, pursuant to such subscription rights, the officers, directors and insiders of the mutual insurance holding company and its subsidiaries and affiliates may not purchase or own, in the aggregate, more than 5 percent of the stock offering for a period of at least six months following the first date the offering was publicly and regularly traded.

b. Requiring a majority of the members of the board of directors of the mutual insurance holding company to be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of such company. The commissioner may waive this requirement upon a showing of good cause.

c. For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the commissioner.

d. Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company, the boards of directors of each such insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company.

e. Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are not interested persons whose responsibility is to evaluate and approve the price of any stock offering.

46.10(4) An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one class of stock provided, however, that at all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary and, provided further, that no class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary.

46.10(5) The commissioner may hire, at the applicant's expense, attorneys, actuaries, accountants, investment bankers and other experts as may reasonably be necessary to assist the commissioner in reviewing the application.

46.10(6) The commissioner may, in the commissioner's discretion, hold a public hearing regarding any application for approval of a stock offering. Upon receipt of an application for approval of a stock offering which includes an initial offering of stock, the commissioner shall hold a public hearing at which all interested parties may appear and present evidence and argument regarding the applicant's planned offering. The commissioner shall provide the applicant adequate notice of the hearing, such that applicant can provide notice of the hearing to members of the mutual insurance holding company, in a manner approved by the commissioner, not less than 20 days prior to the hearing. Following the hearing, the commissioner may approve, conditionally approve, or deny the application. The commissioner may approve the plan if:

a. The offering complies with these rules and other provisions of law,

b. The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions, and

c. The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company.

None of the foregoing shall be deemed to prohibit the filing of a registration statement with the Securities and Exchange Commission prior to or concurrently with the giving of notice to members.

46.10(7) Notwithstanding the provisions of 46.10(1) to 46.10(6) above, stock offerings which are not an initial stock offering, and which offer stock regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the commissioner, or designated on the national association of securities dealers automated quotations—national market system (NASDAQ), may be sold in accordance with the following procedure: If a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this subrule, that entity shall deliver to the commissioner, not less than 30 days prior to the offering, a notice of the planned stock offering and information regarding *(a)* the total number of shares intended to be offered, *(b)* the intended date of sale, *(c)* evidence the stock is regularly traded on one of the public exchanges noted above, and *(d)* a record of the trading price and trading volume of the stock during the prior 52 weeks. The commissioner shall be deemed to have approved the sale unless, within 30 days following receipt of such notice, the commissioner issues an objection to the sale. If the commissioner issues an objection to the sale, the procedures set forth in subrule 46.10(2) shall be followed to determine whether the commissioner approves of the proposed sale.

46.10(8) Approval of a stock offering obtained under either subrule 46.10(6) or 46.10(7) above shall expire 90 days following the date of the approval or deemed approval, except as otherwise provided by order of the commissioner.

46.10(9) No prospectus, information, sales material or sales presentation by the applicant, or by any representative, agent or affiliate of the applicant, shall contain a representation that the commissioner's approval of a stock offering constitutes an endorsement of the price, price range, or any other information relating to the stock.

46.10(10) The following practices are prohibited:

a. Borrowing funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering.

b. Payment of commissions, "special fees" and any other special payments or extraordinary compensation to officers, directors, interested persons and affiliates, for arranging, promoting, aiding or assisting in reorganization to a mutual insurance holding company, or for arranging, promoting, aiding, assisting or participating in the structuring and placement of a stock offering.

c. Entering into an understanding or agreement transferring legal or beneficial ownership of stock to another person in avoidance of these rules.

191—46.11(521A) Regulation of holding company system.

46.11(1) A mutual insurance holding company, and its subsidiaries and affiliates, shall be subject to all provisions of Iowa Code chapter 521A, "Insurance Holding Company Systems." In addition to the provisions of that chapter, all material transactions, as that term is defined in Iowa Code chapters 521A and 521D, between subsidiaries and affiliates of the mutual insurance holding company must be approved by a majority of the directors of the mutual insurance holding company as being both *(a)* fair and reasonable and *(b)* made on terms and conditions not less favorable than those available from unaffiliated third parties.

46.11(2) If the commissioner finds, after notice and hearing, that activities within a mutual insurance holding company system have violated provisions of the Iowa Code, have violated administrative rules, or act to circumvent requirements or prohibitions contained in the Iowa Code or administrative rules, the commissioner may prohibit or order rescission of any transaction relating to those activities.

191—46.12(521A) Reporting of stock ownership and transactions.

46.12(1) Any director or officer of a mutual insurance holding company, its subsidiary or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any member of the mutual insurance holding company system shall, within 15 days following the transaction, file with the insurance commissioner a statement of the transaction on the form prescribed by the commissioner.

46.12(2) A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the commissioner, within 15 days of receipt, copies of Form 3, Form 4 and Schedule 13D, or any equivalent filings, such filings made under the Securities Exchange Act of 1934, as amended.

These rules are intended to implement Iowa Code Supplement section 521A.14 as amended by 1996 Iowa Acts, chapter 1014.

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CHAPTER 47
VALUATION OF LIFE INSURANCE POLICIES

(Including New Select Mortality Factors)

191—47.1(508) Purpose. The purpose of this chapter is to provide tables of select mortality factors and rules for their use, rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits, and rules concerning a minimum standard for the valuation of plans with secondary guarantees. The method for calculating basic reserves defined in this chapter will constitute the commissioners' reserve valuation method for policies to which this chapter is applicable. This chapter is issued under the authority of Iowa Code section 508.36(3)*"a"*(3)(c) and is intended to implement Iowa Code section 508.36(6)*"c."*

191—47.2(508) Application. This chapter shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after February 16, 2000, subject to the following exceptions and conditions.

47.2(1) This chapter shall not apply to any of the following:

a. Any individual life insurance policy issued on or after February 16, 2000, if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before February 16, 2000, that guarantees the premium rates of the new policy. This chapter shall also not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

b. Any universal life insurance policy that meets all the following requirements:

(1) Secondary guarantee period, if any, is five years or less;

(2) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in rule 47.3(508) and the applicable valuation interest rate; and

(3) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

c. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

d. Any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

e. A group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

47.2(2) Conditions.

a. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of rule 47.5(508).

b. Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of rule 47.6(508).

191—47.3(508) Definitions. As used in this chapter, the following definitions apply:

"Basic reserves" means reserves calculated in accordance with Iowa Code section 508.36(6).

"Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in this rule (or any other valuation mortality table adopted by the National Association of

Insurance Commissioners (NAIC) after January 1, 2000, and promulgated by rule by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in subrule 47.4(2).

The length of a particular contract segment shall be set equal to the minimum of the value *t* for which G_t is greater than R_t (if G_t never exceeds R_t, the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; *t* is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$, However, R_t may be increased or decreased by 1 percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and

$q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of paragraph 47.4(2)*"b"* if paragraph 47.4(2)*"c"* is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

"Deficiency reserves" means the excess, if greater than zero, of

1. Minimum reserves calculated in accordance with Iowa Code section 508.36(10) over
2. Basic reserves.

"Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

"Maximum valuation interest rates" means the interest rates defined in Iowa Code section 508.36(5) that are to be used in determining the minimum standard for the valuation of life insurance policies.

"1980 CSO valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

"Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in paragraph 47.6(1)*"c,"* if any, or else the minimum premium described in paragraph 47.6(1)*"d."*

"Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

1. The present value of the death benefits within the segment, plus

2. The present value of any unusual guaranteed cash value (see subrule 47.5(4)) occurring at the end of the segment, less

3. Any unusual guaranteed cash value occurring at the start of the segment, plus

4. For the first segment only, the excess of *"a"* over *"b"* below, as follows:

a. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

b. A net one-year term premium for the benefits provided for in the first policy year.

The length of each segment is determined by the "contract segmentation method," as defined in this rule. The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

For both basic reserves and deficiency reserves computed by the segmentation method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

"Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

"Ten-year select factors" means the select factors adopted with the 1980 amendments to the NAIC Standard Valuation Law.

"Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

1. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

2. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of *"a"* over *"b"* below, as follows:

a. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

b. A net one-year term premium for the benefits provided for in the first policy year.

The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

"Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

191—47.4(508) General calculation requirements for basic reserves and premium deficiency reserves.

47.4(1) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after January 1, 2000, and promulgated by rule by the commissioner for this purpose). If select mortality factors are elected, they may be:

a. The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

b. The select mortality factors in the appendix to this chapter; or

c. Any other table of select mortality factors adopted by the NAIC after February 16, 2000, and promulgated by rule by the commissioner for the purpose of calculating basic reserves.

47.4(2) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after February 16, 2000, and promulgated by rule by the commissioner). If select mortality factors are elected, they may be:

a. The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

b. The select mortality factors in the appendix of this chapter;

c. For durations in the first segment, X percent of the select mortality factors in the appendix, subject to the following:

(1) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(2) X shall not be less than 20 percent;

(3) X shall not decrease in any successive policy years;

(4) X is such that, when using the valuation interest rate used for basic reserves, "1" below is greater than or equal to "2";

1. The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

2. The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(5) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

(6) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of paragraph 47.4(2)*"c"*;

(7) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of paragraph 47.4(2)*"c"*; and

(8) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(9) If X is less than 100 percent at any duration for any policy, the following requirements shall be met:

1. The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of 191—subrule 5.34(3); and

2. The appointed actuary shall annually opine for all policies subject to this chapter as to whether the mortality rates resulting from the application of X meet the requirements of paragraph 47.4(2)*"c."* This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

d. Any other table of select mortality factors adopted by the NAIC after January 1, 2000, and promulgated by rule by the commissioner for the purpose of calculating deficiency reserves.

47.4(3) This rule applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten years,

the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the tenth policy year from the date of issue.

47.4(4) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

47.4(5) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

47.4(6) The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to February 16, 2000. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of 191—subrule 5.34(8).

191—47.5(508) Calculation of minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies).

47.5(1) *Basic reserves.* Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in paragraph *"a"* or *"b"* below may be made:

a. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

b. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

47.5(2) *Deficiency reserves.*

a. The deficiency reserve at any duration shall be calculated:

(1) On a unitary basis if the corresponding basic reserve determined by subrule 47.5(1) is unitary;

(2) On a segmented basis if the corresponding basic reserve determined by subrule 47.5(1) is segmented; or

(3) On a segmented basis if the corresponding basic reserve determined by subrule 47.5(1) is equal to both the segmented reserve and the unitary reserve.

b. This rule shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality in subrule 47.4(2) and rate of interest.

c. Deficiency reserves, if any, shall be calculated for each policy, as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in subrule 47.4(2).

d. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

47.5(3) *Minimum value.* Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the

same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

47.5(4) *Unusual pattern of guaranteed cash surrender values.*

a. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

b. The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where

(1) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

1. The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

2. The mandatory expiration date of the policy; and

(2) The net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(3) The net to gross ratio is equal to "1" divided by "2" below as follows:

1. The present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the *n* year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period.

2. The present value, at the beginning of the *n* year period, of the scheduled gross premiums payable during the *n* year period.

c. For purposes of this subrule, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(1) One hundred ten percent of the scheduled gross premium for that year;

(2) One hundred ten percent of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(3) Five percent of the first policy year surrender charge, if any.

47.5(5) *Optional exemption for yearly renewable term (YRT) reinsurance.* At the option of the company, the following approach for reserves on YRT reinsurance may be used:

a. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

b. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subrule 47.5(3).

c. Deficiency reserves.

(1) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(2) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (1) above.

d. For purposes of this subrule, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, by the NAIC and promulgated by rule by the commissioner for this purpose.

e. A reinsurance agreement shall be considered YRT reinsurance for purposes of this subrule if only the mortality risk is reinsured.

f. If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

47.5(6) *Optional exemption for attained-age-based yearly renewable term (YRT) life insurance policies.* At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used:

a. Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

b. Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subrule 47.5(3).

c. Deficiency reserves.

(1) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(2) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (1) above.

d. For purposes of this subrule, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, by the NAIC and promulgated by rule by the commissioner for this purpose.

e. A policy shall be considered an attained-age-based YRT life insurance policy for purposes of this subrule if:

(1) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(2) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

f. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subrule may be used after the initial period if:

(1) The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(2) The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(3) After the initial period of coverage, the policy meets the conditions of paragraph *"e"* above.

g. If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after January 1, 2000.

47.5(7) *Exemption from unitary reserves for certain n year renewable term life insurance polices.* Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

a. The policy consists of a series of *n* year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, *n* may be truncated or extended to reach the expiry age, provided that this final renewal period is less than ten years and less than twice the size of the earlier *n* year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

b. The guaranteed gross premiums in all *n* year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten-year select mortality factors; and

c. There are no cash surrender values in any policy year.

47.5(8) *Exemption from unitary reserves for certain juvenile policies.* Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

a. At issue, the insured is aged 24 years or younger;

b. Until the insured reaches the end of the juvenile period, which shall occur at or before the age of 25, the gross premiums and death benefits are level, and there are no cash surrender values; and

c. After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

191—47.6(508) Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyowner to keep a policy in force over a secondary guarantee period.

47.6(1) *General.*

a. Policies with a secondary guarantee include:

(1) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(2) A policy in which the minimum premium at any duration is less than the corresponding one-year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after January 1, 2000, by the NAIC and promulgated by rule by the commissioner for this purpose; or

(3) A policy with any combination of subparagraphs (1) and (2).

b. A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in subrules 47.6(2) and 47.6(3) shall be recalculated from issue to reflect these changes.

c. Specified premiums mean the premiums specified in the policy, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

d. For purposes of this rule, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

e. The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in paragraphs 47.4(2)*"b," "c,"* and *"d"* may not be used to calculate the one-year valuation premiums.

f. The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

47.6(2) *Basic reserves for the secondary guarantees.* Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force, and the segments will be determined according to the contract segmentation method as defined in rule 47.3(508).

47.6(3) *Deficiency reserves for the secondary guarantees.* Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as

described in subrule 47.5(2) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

47.6(4) *Minimum reserves.* The minimum reserves during the secondary guarantee period are the greater of:

a. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

b. The minimum reserves required by other rules or rules governing universal life plans.

191—47.7(508) 2001 CSO Mortality Table. The 2001 CSO Mortality Table shall be used for purposes of this chapter pursuant to the requirements of 191—Chapter 91.

These rules are intended to implement Iowa Code section 508.36(6)*"c."*

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Appendix
SELECT MORTALITY FACTORS

This appendix contains tables of select mortality factors that are the bases to which the respective percentage of paragraphs 47.4(1)*"b,"* 47.4(2)*"b,"* and 47.4(2)*"c"* are applied.

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male non-smoker, (3) male smoker, (4) female aggregate, (5) female non-smoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.

For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are 80 percent of the appropriate male table in this Appendix, plus 20 percent of the appropriate female table in this Appendix.

SELECT MORTALITY FACTORS

Male Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100

Male Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100

Male Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Male Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100

Male Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100

Male Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100

Female Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100

Female Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Female Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100

Female Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100

Female Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

VIATICAL AND LIFE SETTLEMENTS

CHAPTER 48
VIATICAL AND LIFE SETTLEMENTS

191—48.1(508E) Purpose and authority. The purpose of this chapter is to provide for the administration of viatical and life settlements in this state by providing rules under which viatical and life settlements may be made, disclosures and other provisions by which viators may be protected, and safeguards by which viatical settlement providers may be monitored and remain in good standing. These rules are adopted by the commissioner pursuant to the authority in Iowa Code chapter 508E.
[**ARC 7729B**, IAB 4/22/09, effective 4/3/09]

191—48.2(508E) Definitions. For purposes of this chapter, the definitions in Iowa Code chapter 508E are incorporated by reference. In addition, the following definitions shall apply:

"Commissioner's Web site" means the Web site of the commissioner and of the Iowa insurance division, www.iid.state.ia.us.

"Life settlement" means a viatical settlement in which the viator has not been diagnosed as terminally or chronically ill. For purposes of these rules, unless otherwise distinguished, the term "life settlement" shall be synonymous with viatical settlement.
[**ARC 7729B**, IAB 4/22/09, effective 4/3/09]

191—48.3(508E) License requirements.

48.3(1) *Viatical settlement provider.*

a. To be considered for licensure as a viatical settlement provider pursuant to Iowa Code section 508E.3, a person must complete the viatical settlement provider application form found at the commissioner's Web site, file with the commissioner the completed application in the format prescribed by the commissioner, and include the payment of an application fee in the amount of $100. An application shall not be deemed filed until all information necessary to process the application has been received by the commissioner. In addition to complying with Iowa Code section 508E.3, the applicant also shall provide the following:

(1) Copies of the provider's audited financial statements for the current year and each of the previous five years. At the commissioner's discretion, the applicant also shall provide a copy of the current year's consolidated annual audited financial statement with a financial guarantee from the provider's ultimate controlling person, and copies of the provider's unaudited financial statements for the current year and each of the previous five years;

(2) Evidence that the applicant maintains books and records in compliance with generally accepted accounting principles;

(3) If a legal entity intending to have any partners, officers, members, and designated employees act as viatical settlement providers or viatical settlement brokers under the legal entity's license pursuant to Iowa Code section 508E.3, all completed forms, fees, and information required to be filed under subrule 48.3(2) for each such person named in the application and any supplements to the application;

(4) Biographical affidavits, in a form prescribed by the commissioner, for the following: officers and directors (as listed on the most recent financial statement), key managerial personnel (including any vice presidents or other individuals who will control the operations of the applicant), and individuals with a 10 percent or more beneficial ownership in the applicant who will exercise control over the applicant;

(5) An independent business character report on the individuals listed in subparagraph (4). The business character report shall be filed directly with the commissioner by the independent third party that certified the report. The business character report shall be in a format prescribed by the commissioner and shall not be older than one year prior to the date the application is filed. For purposes of subparagraph (5), "business character report" means a statement certified by an independent third party which has conducted a comprehensive review of the applicant's background and has indicated that the biographical information provided in the report, as completed by the applicant, has no inaccurate or conflicting information. An independent third party is one that has no affiliation with the applicant and is in the business of providing background checks or investigations. Business character reports must

be current and shall not be older than one year prior to the date the application is filed. The business character report shall be in the format prescribed by the commissioner;

(6) Initial viatical settlement contracts, disclosure statements, and advertising material that have been or are being submitted for approval and that have been approved or that are approved during the course of the application process pursuant to Iowa Code section 508E.5;

(7) A copy of the provider trust, pursuant to 48.3(1)*"c"*; and

(8) A report of any civil, criminal or administrative actions taken or pending against the viatical settlement provider in any state or federal court or agency, regardless of outcome.

b. A form for the antifraud plan that is required to be submitted with an application pursuant to Iowa Code section 508E.3, to meet the requirements of Iowa Code section 508E.15, can be found on the commissioner's Web site.

c. The provider trust that is required to be submitted with an application, pursuant to subparagraph 48.3(1)*"a"*(7), shall be in a format acceptable to the commissioner and shall include the following provisions:

(1) The provider trust cannot be terminated without the prior written consent of the commissioner.

(2) The provider trust is subject to the prior approval of the commissioner.

(3) The provider trust funds shall not be intermingled.

(4) The provider trust funds held shall be identified based on individual policyholders.

(5) The provider trust trustee is obligated to indemnify the provider or the policyholder or both for any lost funds.

(6) The agreement can only be amended or terminated with the prior written consent of the commissioner.

(7) The provider trust trustee shall be a bank or trust company, having its principal place of business in the United States.

(8) The provider trust trustee shall be audited annually by independent public accountants and complete the audit report, related financial statements, and opinion on internal controls. All reports shall be available for review by the commissioner.

d. In addition to the information required in this subrule, the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement provider complies with the requirements of this subrule and Iowa Code subsection 508E.3(7).

48.3(2) *Viatical settlement broker.*

a. To be considered for licensure as a viatical settlement broker pursuant to Iowa Code section 508E.3, a person must complete the viatical settlement broker application form found at the commissioner's Web site, file the completed application in the format prescribed by the commissioner, and include the payment of an application fee in the amount of $100. In addition to finding compliance with Iowa Code section 508E.3, the commissioner also shall find that the applicant:

(1) Has provided proof of one of the following:

1. The applicant is a licensed insurance producer with a life line of authority for at least the 12 months preceding the date of application; or

2. The applicant has taken and passed an examination on viatical and life settlement contracts required by another state insurance department and currently holds a license as a viatical settlement broker from that state; or

3. The applicant has passed the viatical settlement examination required by the commissioner. Examination results are valid for 90 days after the date of the examination. If the applicant fails to apply for licensure within 90 days after passing the examination, the examination results shall be void;

(2) Has provided a report of any civil, criminal or administrative actions taken or pending against the viatical settlement broker in any state or federal court or agency, regardless of outcome, excluding misdemeanor traffic citations and juvenile offenses; and

(3) Has provided proof that the applicant is covered by an errors and omissions policy for an amount of not less than $100,000 liability per occurrence and not less than $100,000 total annual aggregate for all claims during the policy period.

b. A form for the antifraud plan that is required to be submitted with an application pursuant to Iowa Code section 508E.3, to meet the requirements of Iowa Code section 508E.15, can be found on the commissioner's Web site.

c. In addition to the information required in this subrule, the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement broker complies with the requirements of this subrule and has made a filing pursuant to Iowa Code subsection 508E.3(7).

48.3(3) *Governing law where viators are residents of different states.* For purposes of this subrule, if there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement contract shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators. If another state does not have a statute or rule substantially similar to Iowa Code chapter 508E and this rule, the actions related to the viatical settlement contract shall be governed by the law of this state.

48.3(4) *License term.*

a. A viatical settlement provider or viatical settlement broker who meets the requirements of this rule, unless otherwise denied licensure pursuant to rule 48.10(508E), shall be issued a license.

b. A viatical settlement provider license is valid for one year and automatically terminates on the last day of the month of the anniversary of the issue date unless renewed pursuant to subrule 48.3(6).

c. A viatical settlement broker license is valid for an initial term of one year from the last day of the applicant's anniversary month following the issuance of the license, and automatically terminates on the last day of the month of the initial term unless renewed pursuant to subrule 48.3(6).

d. A viatical settlement provider license or a viatical settlement broker license may remain in effect for the term of the license plus any renewals, unless the license is revoked or suspended, as long as all required fees are paid in the time prescribed by the commissioner.

e. The license issued to a viatical settlement provider or viatical settlement broker shall be a limited license that allows the licensee to operate only within the scope of its license.

48.3(5) *Continuing education for viatical settlement broker.*

a. An individual licensed as a viatical settlement broker shall complete 15 credits of approved continuing education during every two license terms. A license term is as set forth in paragraph 48.3(4)*"c,"* and, for purposes of this rule, the two-term continuing education requirement shall be called the "CE reporting term."

b. The required continuing education credits shall include a minimum of:

(1) Thirteen credits related to viatical settlements and viatical settlement transactions; and

(2) Two credits in ethics.

c. The viatical settlement broker may submit the same completed credits to the commissioner both to meet the continuing education requirements for the viatical settlement broker license and to meet the continuing education requirements for an applicable insurance producer license.

d. The license of a viatical settlement broker who fails to comply with this continuing education requirement shall terminate.

e. An instructor of an approved continuing education course shall be granted the same credit as a student who completes the continuing education course, and the instructor may receive such credit once during a license term.

f. A viatical settlement broker cannot carry over from one CE reporting term to the next continuing education credits earned in excess of the viatical settlement broker's CE reporting term requirements.

g. A viatical settlement broker may receive continuing education credit for self-study courses. A self-study course is considered completed when the continuing education provider receives the completed examination from the viatical settlement broker.

(1) A viatical settlement broker may receive continuing education credit for self-study courses that are part of a recognized national designation program as described in 191—subrule 11.5(5).

(2) A viatical settlement broker may receive continuing education credits for self-study courses that do not meet the requirement of subparagraph (1) if the viatical settlement broker:

1. Submits an affidavit to the continuing education provider that the examination was independently proctored and was completed without any outside assistance, and

2. Correctly answers at least 70 percent of the questions presented.

h. A viatical settlement broker shall not receive continuing education credit for courses taken prior to the issuance of an initial license.

i. A viatical settlement broker cannot receive continuing education credit for the same course twice in one CE reporting term. A viatical settlement broker cannot receive continuing education credit both for the classroom portion and for the examination portion of a national designation program as defined in 191—subrule 11.5(5).

j. A viatical settlement broker may elect to comply with the continuing education requirements by taking and passing the viatical settlement broker licensing examination within 90 days prior to the date on which the renewal application is submitted.

k. A viatical settlement broker shall demonstrate compliance with the continuing education requirements at the time of license renewal. A viatical settlement broker shall maintain a record of all continuing education courses completed by keeping the original certificates of completion for four years after the end of the year of course completion.

l. For purposes of rule 191—48.3(508E), "credit" means continuing education credit. One credit is 50 minutes of instruction or reading material in an acceptable topic.

m. Viatical settlement broker continuing education courses will be approved in the same manner that insurance continuing education courses are approved pursuant to 191—Chapter 11. The approval of continuing education providers, the responsibilities of continuing education providers, the prohibited conduct for continuing education providers, and the fees for approval and renewal of continuing education providers and courses shall be the same as those for insurance continuing education courses, continuing education providers, and insurance producers set forth in rules 191—11.9(505,522B) to 191—11.11(505,522B) and 191—11.14(505,522B). The commissioner may enter into a contractual arrangement with a qualified outside vendor to assist the commissioner with any or all continuing education services in the same manner as the commissioner may for insurance continuing education services pursuant to rule 191—11.12(505,522B). The commissioner may audit any continuing education course in the same manner as the commissioner may for insurance continuing education courses pursuant to rule 191—11.13(505,522B).

48.3(6) *License renewal.* A viatical settlement provider license or a viatical settlement broker license may be renewed as follows:

a. A viatical settlement provider license may be renewed by payment of $100 within 60 days prior to the expiration date of the license and by demonstration that the viatical settlement provider continues to meet the requirements of Iowa Code section 508E.3 and subrule 48.3(1), has provided biographical affidavits not older than one year prior to the renewal date on all persons listed in subparagraph 48.3(1)*"a"*(4), has provided business character reports for any new persons listed in subparagraph 48.3(1)*"a"*(4), and has provided the reports required by rule 48.7(508E).

(1) If renewal is approved, the license will be renewed effective the last day of the month of the anniversary of the issue date in the renewal year, will be valid for one year, and will automatically terminate on the last day of the month of the anniversary of the issue date in the following renewal year unless renewed pursuant to subrule 48.3(6).

(2) Viatical settlement providers that had licenses prior to January 1, 2009, shall have a renewal date of January 1.

b. A viatical settlement broker license may be renewed by demonstration of completion of continuing education as required in subrule 48.3(5) and payment of $100 within 60 days prior to the expiration date of the license. If renewal is approved, the license will be renewed effective the last day of the month of the anniversary of the issue date in the renewal year, will be valid for one year, and will automatically terminate on the last day of the month of the anniversary of the issue date in the following renewal year unless renewed pursuant to subrule 48.3(6).

c. If a legal entity has any partners, officers, members, or designated employees acting as viatical settlement providers or viatical settlement brokers under the legal entity's license pursuant to Iowa Code

section 508E.3, the legal entity must provide all completed forms, fees, and information required to be filed under paragraphs 48.3(6)*"a"* and *"b"* for each such person named in the application, or in any supplements to the application, and must provide any deletions to the list of names that was provided with the original application. If there are any new partners, officers, members, and designated employees that the legal entity intends will act as viatical settlement providers or viatical settlement brokers under the legal entity's license, the legal entity shall provide for each such person the forms, information and fees required by subrule 48.3(2).

d. If a viatical settlement provider or viatical settlement broker fails to comply with the renewal procedures within the time prescribed, or a viatical settlement provider fails either to meet the requirements of Iowa Code section 508E.3 and subrule 48.3(1) or to submit the reports required in rule 48.7(508E), such nonpayment or failure shall result in lapse of the license.

e. A licensed viatical settlement broker who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request from the commissioner a waiver of renewal procedures. Such viatical settlement broker may also request a waiver of any examination requirement or any other penalty or sanction imposed for failure to comply with renewal procedures.

48.3(7) *License reinstatement.*

a. A viatical settlement broker may reinstate an expired license up to 12 months after the license expiration date by proving that during the CE reporting term the viatical settlement broker met the CE requirements found in subrule 48.3(5), and by paying to the commissioner a reinstatement fee and license renewal fee. A viatical settlement broker who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

b. A viatical settlement broker who has surrendered a license for a nondisciplinary reason and stated an intent to exit the viatical settlement business may file a request to reactivate the license. The request must be received by the commissioner within 90 days of the date the license was placed on inactive status. The request will be granted if the former viatical settlement broker is otherwise eligible to receive the license. If the request is not received within 90 days, the viatical settlement broker must apply for a new license.

48.3(8) *Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.*

a. The term "reinstatement" as used in this subrule means the reinstatement of a suspended license. The term "reissuance" as used in this subrule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter. This subrule does not apply to the reinstatement of an expired license.

b. Any viatical settlement broker whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

(1) All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license.

(2) An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

(3) A viatical settlement broker may request reinstatement of a suspended license prior to the end of the suspension term.

(4) Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding 191—paragraph 10.10(2)*"c"*), revocation, or acceptance of the forfeiture of a license.

c. All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

d. An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems desirable, which may include one or more of the types of disciplinary sanctions provided by this chapter or by Iowa Code chapter 508E. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapter 22.

e. A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

f. A license may be voluntarily forfeited in lieu of compliance with an order of the commissioner or the commissioner's designee with the written consent of the commissioner. The forfeiture becomes effective when and upon such conditions as required by order of the commissioner, which may include one or more of the types of disciplinary sanctions provided by this chapter or by Iowa Code chapter 508E.

g. When a viatical settlement broker's license has been suspended for a period of time which extends beyond the viatical settlement broker's license expiration date, the license will terminate at the license expiration date, and the viatical settlement broker must request reinstatement pursuant to subrule 48.3(7). If suspension for a period of time ends prior to the viatical settlement broker's license expiration date, the commissioner shall reinstate the license at the end of the suspension period pursuant to paragraph 48.3(8)*"b."* The commissioner is not prohibited from bringing an additional immediate action if the viatical settlement broker has engaged in misconduct during the period of suspension.

48.3(9) *Duty to notify commissioner of cessation of business in the state.* If a viatical settlement provider intends to cease business in Iowa, it must notify the commissioner of those intentions and of its plan of operation for such cessation at least 180 days before the cessation shall occur. This requirement is not meant to imply that a company must continue to accept new viatical or life settlement business during the 180-day period.

48.3(10) *Duty to notify commissioner of changes.*

a. A viatical settlement provider shall provide to the commissioner any new or revised information about officers, stockholders holding 10 percent or more of the stock of the company, partners, directors, members or designated employees within 30 days of the date the addition or revision occurred.

b. A viatical settlement provider or viatical settlement broker shall inform the commissioner in writing of any change of name or address within 30 days of the date of such change. In addition, a viatical settlement provider shall provide the commissioner with 30 days' notice of the cancellation or nonrenewal of a fidelity bond required for licensure under subrule 48.3(1) and the name of the carrier that will be providing coverage subsequent to such cancellation or nonrenewal.

c. A viatical settlement provider or viatical settlement broker shall report to the commissioner any administrative action taken against the viatical settlement provider or viatical settlement broker in another state or federal jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to the order, or other relevant legal documents. Within 30 days of the initial pretrial hearing date, a viatical settlement provider or viatical settlement broker shall report to the commissioner any criminal prosecution of the viatical settlement provider or viatical settlement broker taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

48.3(11) *Commissioner may use outside assistance.* In order to assist with the commissioner's duties, the commissioner may contract with a nongovernmental entity, including, but not limited to, the National Association of Insurance Commissioners (NAIC) or any affiliate or subsidiary the NAIC oversees, to perform any ministerial functions related to licensing of viatical settlement providers or viatical settlement brokers that the commissioner deems appropriate including, but not limited to, the collection of fees.

48.3(12) *Fees.*

a. Fees shall be paid by check.

b. The fee for an examination shall be set by the outside testing service under contract with the division and approved by the division.

c. The annual fee for issuance or renewal of a viatical broker, legal entity or provider license is $100.

d. The fee for reinstatement of a viatical broker, legal entity or provider license is the sum of the renewal fee plus $100.

e. The division may charge a reasonable fee for the compilation and production of viatical broker, legal entity or provider licensing records.

[**ARC 7729B**, IAB 4/22/09, effective 4/3/09]

191—48.4(508E) Disclosure statements.

48.4(1) If a viatical settlement provider enters into a viatical settlement contract that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following:

a. A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated and that benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

b. A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either:

(1) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

(2) Send to the insured a copy of the document(s) sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and

c. A provision that apportions the premiums to be paid by the viatical settlement provider and the viator. It is permissible for the viatical settlement contract to specify that all premiums shall be paid by the viatical settlement provider. The viatical settlement contract also may require that the viator reimburse the viatical settlement provider only for the premiums attributable to the retained interest.

48.4(2) With each application for a viatical settlement contract, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosure no later than the time the application for the viatical settlement contract is signed by the viator and the viatical settlement broker. The disclosure shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall advise the viator that, when entering into a viatical settlement contract, having a recent physical examination is in the viator's best interest, since an accurate life expectancy can be best calculated based on current medical records.

48.4(3) If the viator is not the insured, then these disclosures must be affirmatively made to the insured, as well as to the viator, and written consent to the viatication must be received from both parties.

191—48.5(508E) Contract requirements. In order to ensure that viators receive a reasonable return for viaticating an insurance policy when life expectancy is less than 25 months, a viatical settlement provider shall pay to a viator a discounted amount of the face value of the policy which amount shall be calculated at least at the following rates:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 25 months	60%
25 months or more	Cash surrender value of policy

The percentage may be reduced by 5% for viaticating a policy written by an insurer rated less than the highest four categories by A.M. Best, or a comparable rating by another rating agency.

For a viatical settlement in which the viator has a life expectancy of 25 months or more, a viatical settlement provider or broker shall not enter into a viatical settlement contract that provides a payment to the viator that is unreasonable or unjust. As listed above, such payment must at least be equal to the cash surrender value of the policy. In determining whether a payment is unreasonable or unjust, the commissioner may consider, among other factors, the life expectancy of the insured; the applicable rating of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups; and prevailing discount rates in the viatical and life settlement market in Iowa or, if insufficient data is available for Iowa, the prevailing rates nationally or in other states that maintain this data.

191—48.6(508E) Filing of forms. If a viatical settlement provider subsequently desires to change the viatical settlement contract documents or disclosure statements approved at the time of licensure, or to use new ones, the provider shall submit the new or modified contract documents or disclosure statements to the commissioner for approval in triplicate, along with a postage-paid return envelope. The viatical settlement provider shall identify its name and address in the cover letter and also reference the form number of the modified viatical settlement contract document or disclosure statement. Black-lining the modifications made within the document(s) should expedite the form review and approval process.

191—48.7(508E) Reporting requirements.

48.7(1) On March 1 of each calendar year, the secretary and either the president or the vice president of each viatical settlement provider licensed in this state shall submit, under oath, the following: the annual statement required by Iowa Code section 508E.6; a report of all viatical settlement transactions in which the viator is a resident of this state; and a report for all states in the aggregate. The report shall contain the following information for the previous calendar year:

a. For viatical settlements contracted during the reporting period:

(1) Date of viatical settlement contract;

(2) Viator's state of residence at the time of the contract;

(3) Mean life expectancy, in months, of the insured at time of contract;

(4) Face amount of policy viaticated;

(5) Net death benefit viaticated;

(6) Estimated total premiums to keep policy in force for mean life expectancy;

(7) Net amount paid to viator;

(8) Source of policy (B-Broker; D-Direct Purchase; SM-Secondary Market);

(9) Type of coverage (I-Individual; G-Group);

(10) Within the contestable or suicide period, or both, at the time of viatical settlement (yes or no);

(11) If the insured is diagnosed as terminally or chronically ill, the general disease classification applicable to such insured; and

(12) Type of funding (I-Institutional; P-Private).

b. For viatical settlements in which death of the insured has occurred during the reporting period:

(1) Date of viatical settlement contract;

(2) Viator's state of residence at the time of the contract;

(3) Mean life expectancy, in months, of the insured at time of contract;

(4) Net death benefit collected;

(5) Total premiums paid to maintain the policy (WP-Waiver of Premium; NA-Not Applicable);

(6) Net amount paid to viator;

(7) If the insured was diagnosed as terminally or chronically ill, the general disease classification applicable to such insured;

(8) Date of death of insured;

(9) Amount of time, in months, between date of contract and date of death of insured;

(10) Difference between the number of months that passed between the date of contract and the date of death of insured and the mean life expectancy in months as determined by the reporting company;

c. Name and address of each viatical settlement broker through whom the reporting company purchased a policy from a viator who resided in this state at the time of contract;

d. Number of policies reviewed and rejected; and

e. Number of policies purchased from persons other than a viator (on the secondary market) as a percentage of total policies purchased.

48.7(2) On or before March 1 of each year, the secretary and either the president or the vice president of each viatical settlement provider licensed in this state shall make a report under oath of the following or shall provide the following documentation:

a. That the viatical settlement provider has at all times maintained books and records in compliance with generally accepted accounting principles;

b. That the viatical settlement provider has obtained and furnished to the commissioner either:

(1) A copy of the current year's audited financial statement; or

(2) At the commissioner's discretion, a copy of the current year's consolidated annual audited financial statement with a financial guarantee from the provider's ultimate controlling person; and

c. That the viatical settlement provider has maintained fidelity bonds on each officer and director in the amount of $100,000.

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191—48.8(508E) Examination or investigations.

48.8(1) *Authority, scope and scheduling of examinations.* In addition to the authority, scope and scheduling of examinations set forth in Iowa Code section 508E.7, the following provisions shall apply:

a. The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

b. The provisions of Iowa Code chapter 507 shall apply to viatical settlement providers and viatical settlement brokers. The expense of examinations shall be assessed against the viatical settlement provider in the same manner as insurers are assessed for examinations.

c. Neither the commissioner nor any person that received the documents, material or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to this subrule.

48.8(2) *Immunity from liability.* No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this rule or of Iowa Code chapter 508E.

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191—48.9(508E) Requirements and prohibitions.

48.9(1) With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

48.9(2) Payment of the proceeds to the viator pursuant to a viatical settlement contract shall be made in a lump sum except where the viatical settlement provider has purchased a single-premium paid-up annuity issued by a licensed insurance company to the viator. Retention of a portion of the proceeds by the viatical settlement provider or escrow agent is not permissible. For purposes of this subrule, "escrow agent" means an individual or institution that has established an escrow or trust account with a state-chartered or federally chartered financial institution whose deposits and accounts are insured by the Federal Deposit Insurance Corporation (FDIC) and with which an escrow account has been established for use by a viatical settlement provider or viatical settlement purchaser.

48.9(3) If a viatical settlement provider or viatical settlement broker is served with a subpoena and thereby compelled to produce records containing patient-identifying information, the viatical settlement provider or viatical settlement broker shall notify the viator and the insured in writing at the viator's and the insured's last-known addresses within five business days after receiving notice of the subpoena.

48.9(4) A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, related to the same viatical settlement contract.

48.9(5) A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

48.9(6) A viatical settlement provider shall not use a longer life expectancy than is reasonable based on all medical and actuarial information available at the time of a viatical settlement transaction in order to reduce the payout to which the viator is entitled.

48.9(7) A viatical settlement provider or viatical settlement broker shall not discriminate in the making or solicitation of viatical settlement contracts on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with or without dependents.

48.9(8) A viatical settlement provider or viatical settlement broker shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to an insured or viator, or to any other person acting as an agent of an insured or viator with respect to a viatical settlement contract.

48.9(9) A viatical settlement provider shall not knowingly solicit individuals who have treated or have been asked to treat the illness of an insured whose coverage would be the subject of a viatical settlement contract.

48.9(10) A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this rule in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

48.9(11) In recommending a viatical settlement contract, viatical settlement brokers and viatical settlement providers shall make suitable recommendations.

191—48.10(508E) Penalties; injunctions; civil remedies; cease and desist.

48.10(1) Unfair trade practices. Pursuant to Iowa Code section 508E.17, a violation of rule 48.4(508E), 48.5(508E), 48.6(508E), 48.7(508E) or 48.9(508E) shall be considered an unfair trade practice under Iowa Code chapter 507B, and a violator shall be subject to the penalties contained in that chapter.

48.10(2) Unauthorized insurer. A person doing the activities of a viatical settlement provider or a viatical settlement broker without a license under this chapter shall be deemed an unauthorized insurer and shall be subject to the penalties of Iowa Code chapter 507A.

48.10(3) License revocation and denial. The commissioner may suspend, revoke, refuse to issue, or refuse to renew the license of a viatical settlement provider or viatical settlement broker for violation of rule 48.3(508E).

48.10(4) A viatical settlement provider licensed in this state that in the time required fails to file either the annual statement referred to in Iowa Code section 508E.6 or the annual audited financial statement referred to in subparagraph 48.3(1)*"a"*(1) shall pay an administrative penalty pursuant to Iowa Code

section 508E.16. The viatical settlement provider's right to transact further new business in this state shall immediately cease until the provider has fully complied with this rule.

48.10(5) Pursuant to Iowa Code section 508E.16, if the commissioner finds that an activity in violation of this rule presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains in effect for 90 days. If the commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to 191—Chapters 2 and 3.
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191—48.11(252J) Suspension for failure to pay child support.

48.11(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the viatical settlement broker that the viatical settlement broker's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the viatical settlement broker's last-known address by regular mail.

48.11(2) The notice shall contain the following items:

a. A statement that the commissioner intends to suspend the viatical settlement broker's application, request for renewal or current license in 30 days;

b. A statement that the viatical settlement broker must contact the CSRU to request a withdrawal of the certificate of noncompliance;

c. A statement that the viatical settlement broker's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;

d. A statement that the viatical settlement broker does not have a right to a hearing before the commissioner, but that the viatical settlement broker may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

48.11(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the commissioner is notified by the district court of the resolution of the application.

48.11(4) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the viatical settlement broker's application, request for renewal or current license 30 days after the notice is issued.

48.11(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt, and the named viatical settlement broker shall be notified that the proceedings have been halted. If the viatical settlement broker's license has already been suspended, the license shall be reinstated if the viatical settlement broker is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the viatical settlement broker, and all continuing education requirements must be met before the viatical settlement broker's license will be renewed or reinstated after a license suspension or revocation pursuant to this rule.

191—48.12(261) Suspension for failure to pay student loan.

48.12(1) The commissioner shall deny the issuance or renewal of a viatical settlement broker license upon receipt of a certificate of noncompliance from the college student aid commission (CSAC) according to the procedures set forth in Iowa Code sections 261.126 and 261.127. In addition to the procedures contained in those sections, this rule shall apply.

48.12(2) Upon receipt of a certificate of noncompliance from the CSAC according to the procedures set forth in Iowa Code sections 261.126 and 261.127, the commissioner shall issue a notice to the viatical settlement broker that the viatical settlement broker's pending application for licensure, pending request

for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the viatical settlement broker's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed viatical settlement broker may accept service personally or through authorized counsel.

48.12(3) The notice shall contain the following items:

a. A statement that the commissioner intends to suspend the viatical settlement broker's application, request for renewal or current license in 60 days;

b. A statement that the viatical settlement broker must contact the CSAC to request a withdrawal of the certificate of noncompliance;

c. A statement that the viatical settlement broker's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn or, if the current license is on suspension, a statement that the current license will be revoked;

d. A statement that the viatical settlement broker does not have a right to a hearing before the commissioner, but that the viatical settlement broker may file an application for a hearing in district court pursuant to Iowa Code section 261.127;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

48.12(4) The effective date of revocation or suspension of a viatical settlement broker license, as specified in the notice required by Iowa Code section 261.126, shall be 60 days following service of the notice upon the applicant or licensed viatical settlement broker.

48.12(5) In the event an applicant or licensed viatical settlement broker timely files a district court action following service of notice by the commissioner pursuant to Iowa Code section 261.127, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a viatical settlement broker license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

48.12(6) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSAC or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the viatical settlement broker's application, request for renewal or current license 60 days after the notice is issued.

48.12(7) Upon receipt of a withdrawal of the certificate of noncompliance from the CSAC, suspension proceedings shall halt, and the named viatical settlement broker shall be notified that the proceedings have been halted. If the viatical settlement broker's license has already been suspended, the license shall be reinstated if the viatical settlement broker is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the viatical settlement broker, and all continuing education requirements must be met before the viatical settlement broker's license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code section 261.126.

48.12(8) The commissioner shall notify the viatical settlement broker in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of the viatical settlement broker license, and shall similarly notify the viatical settlement broker when the viatical settlement broker license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

48.12(9) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the CSAC for the sole purpose of identifying viatical settlement brokers subject to enforcement under Iowa Code chapter 261.

191—48.13(272D) Suspension for failure to pay state debt.

48.13(1) The commissioner shall deny the issuance or renewal of a viatical settlement broker license upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures in Iowa Code chapter 272D. In addition to the procedures set forth in Iowa Code chapter 272D, this rule shall apply.

48.13(2) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures set forth in Iowa Code chapter 272D, the commissioner shall issue a notice to the viatical settlement broker that the viatical settlement broker's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the viatical settlement broker's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed viatical settlement broker may accept service personally or through authorized counsel.

48.13(3) Pursuant to Iowa Code section 272D.8, the notice shall contain the following items:

a. A statement that the commissioner intends to suspend the viatical settlement broker's application, request for renewal or current license in 60 days;

b. A statement that the viatical settlement broker must contact the centralized collection unit of the department of revenue to schedule a conference or to otherwise obtain a withdrawal of the certificate of noncompliance;

c. A statement that the viatical settlement broker's application, request for renewal or current license will be suspended or denied if the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue within 30 days of the issuance of notice under this rule; or, if the current license is on suspension, a statement that the viatical settlement broker's current license will be revoked;

d. A statement that the viatical settlement broker does not have a right to a hearing before the commissioner, but that the viatical settlement broker may file an application for a hearing in district court pursuant to Iowa Code section 272D.9;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

48.13(4) Viatical settlement brokers shall keep the commissioner informed of all court actions and all actions taken by the centralized collection unit of the department of revenue under or in connection with Iowa Code chapter 272D; and viatical settlement brokers shall provide to the commissioner, within seven days of filing or issuance, copies of all applications filed with the district court pursuant to Iowa Code section 272D.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the centralized collection unit of the department of revenue.

48.13(5) The effective date of revocation or suspension of a viatical settlement broker license, as specified in the notice required by Iowa Code section 272D.8 and subrule 48.13(2), shall be 60 days following service of the notice upon the applicant or licensed viatical settlement broker.

48.13(6) In the event an applicant or licensed viatical settlement broker timely files a district court action following service of notice by the commissioner pursuant to Iowa Code section 272D.9, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a viatical settlement broker license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

48.13(7) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the viatical settlement broker's application, request for renewal or current license 60 days after the notice is issued.

48.13(8) Upon receipt of a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue, suspension proceedings shall halt, and the named viatical settlement broker shall be notified that the proceedings have been halted. If the viatical settlement broker's license has already been suspended, the license shall be reinstated if the viatical settlement broker is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the viatical settlement broker, and all continuing education requirements must be met before the viatical settlement broker's license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code chapter 272D.

48.13(9) The commissioner shall notify the viatical settlement broker in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of the viatical settlement broker license, and shall similarly notify the viatical settlement broker when the viatical settlement broker license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

48.13(10) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the centralized collection unit of the department of revenue for the sole purpose of identifying viatical settlement brokers subject to enforcement under Iowa Code chapter 272D.

[**ARC 7729B**, IAB 4/22/09, effective 4/3/09]

191—48.14(508E) Severability. If any rule or portion of a rule or its applicability to any person or circumstance is held invalid by a court, the remainder of these rules or the rules' applicability to other persons or circumstances shall not be affected.

[**ARC 7729B**, IAB 4/22/09, effective 4/3/09]

These rules are intended to implement Iowa Code chapters 508E, 252J, 261 and 272D.

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CHAPTER 49
FINANCIAL INSTRUMENTS USED IN HEDGING TRANSACTIONS

191—49.1(511) Purpose. The purpose of these rules is to set standards for the prudent use of financial instruments used in hedging transactions in accordance with Iowa Code section 511.8(22). This chapter shall be applicable to the legal reserve funds for all domestic insurers and United States branches of alien insurers entered through this state.

191—49.2(511) Definitions.

"Business entity" means a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for profit or not for profit.

"Counterparty exposure" means the amount of credit risk attributable to a derivative instrument entered into with a business entity ("over-the-counter derivative instrument"). No counterparty exposure shall be assigned to transactions involving a qualified exchange or qualified foreign exchange or transactions cleared through a qualified clearinghouse.

1. The amount of credit risk equals:

a. The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

b. Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

2. If the over-the-counter derivative instruments are entered into pursuant to a written master agreement which provides for netting of payments owed by the respective parties, and the domicile of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the Purposes and Procedures of the Securities Valuation Office as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

a. The market value of the over-the-counter derivative instruments entered into pursuant to the master agreement, the liquidation of which would result in a final cash payment to the insurer; and

b. The market value of the over-the-counter derivative instruments entered into pursuant to the master agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

For any open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow for the benefit of the insurer by one or both parties.

"Derivative instrument used in a hedging transaction" means an agreement, option, instrument or a series or combination thereof:

1. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

2. That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures and any other agreements, options or instruments substantially similar thereto or any series or combination thereof. Derivative instruments shall additionally include any agreements, options or instruments permitted pursuant to Iowa Code section 511.8(22)*"h."* Derivative instruments shall not include an investment authorized by Iowa Code sections 511.8(1) through 511.8(21).

"Financial instrument used in a hedging transaction" means a derivative instrument used in a hedging transaction.

"Qualified clearinghouse" means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

"Qualified exchange" means:

1. A securities exchange registered as a national securities exchange, or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78 et seq.);

2. A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission or any successor thereof;

3. Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

4. A designated offshore securities market as defined in Securities and Exchange Commission Regulation S, 17 CFR Part 230; or

5. A qualified foreign exchange.

"Qualified foreign exchange" means a foreign exchange, board of trade or contract market located outside the United States, its territories or possessions:

1. That has received regulatory comparability relief pursuant to Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's regulations, 17 CFR Part 30);

2. That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief pursuant to Commodity Futures Trading Commission Rule 30.10 (as set forth in Appendix C to Part 30 of the CFTC's regulations, 17 CFR Part 30) as to futures transactions in the jurisdiction where the exchange, board of trade or contract market is located; or

3. Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's Office of General Counsel, but an exchange, board of trade or contract market that qualifies as a "qualified foreign exchange" only under this paragraph shall only be a "qualified foreign exchange" as to foreign stock index futures contracts that are the subject of such no-action relief under this paragraph.

191—49.3(511) Guidelines and internal control procedures.

49.3(1) Before engaging in a derivative transaction pursuant to Iowa Code section 511.8(22), an insurer shall establish written guidelines that shall be used for effecting and maintaining the transactions. The guidelines shall:

a. Address investment or, if applicable, underwriting objectives, risk constraints, and the factors considered in establishing risk constraints such as credit risk limits;

b. Address permissible transactions and the relationship of those transactions to its operations, such as a precise identification of the risks being hedged by a derivative transaction; and

c. Require compliance with internal control procedures.

49.3(2) An insurer shall have a system for determining whether a derivative instrument used for hedging has been effective. In so doing a company should set specific criteria at the inception of the hedge or hedge program as to what will be considered effective in measuring the hedge and individual hedges in a hedge program and then apply those criteria in the ongoing assessment based on actual hedge results.

49.3(3) An insurer shall have a credit risk management system for over-the-counter derivative transactions that measures credit risk exposure using the counterparty exposure amount as provided in rule 49.2(511).

49.3(4) The board of directors of the insurer or a committee thereof shall, in accordance with Iowa Code section 511.8(22)*"f"*:

a. Approve the guidelines required by subrule 49.3(1) and the systems required by subrules 49.3(2) and 49.3(3); and

b. Determine whether the insurer has adequate professional personnel, technical expertise and systems to implement investment practices involving derivatives.

49.3(5) For purposes of determining whether internal control procedures are in compliance with this rule, the insurance division may consider, but is not limited to, the following items:

a. That only the board or its authorized designee can approve derivative instrument transactions;

b. That the board or its designee exercise administrative oversight of trading functions;

c. That periodic reporting of open positions to chief investment officer occurs; and

d. That periodic assessment of the effectiveness of hedging transactions be conducted by persons designated by the board or its designees.

191—49.4(511) Documentation requirements. An insurer shall maintain documentation and records relating to each derivative transaction transacted pursuant to Iowa Code section 511.8(22) including, but not limited to:

1. The purpose or purposes of the transaction;
2. The assets or liabilities to which the transaction relates;
3. The specific derivative instrument used in the transaction;
4. For over-the-counter derivative instrument transactions, the name of the counterparty and the counterparty exposure amount calculated not less than quarterly; and
5. For exchange traded derivative instruments, the name of the exchange and the name of the firm that handled the trade.

191—49.5(511) Trading requirements. Each derivative instrument qualifying for legal reserve purposes under Iowa Code section 511.8(22) shall be:

1. Traded on a qualified exchange;
2. Entered into with, or guaranteed by, a business entity with an investment grade rating by the NAIC Securities and Valuation Office or by a majority of nationally recognized statistical rating organizations (NRSRO), on the NAIC/NRSRO list, that rate the business entity;
3. Issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or
4. Entered into with a qualified foreign exchange.

These rules are intended to implement Iowa Code section 511.8(22).

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SECURITIES

CHAPTER 50
REGULATION OF SECURITIES OFFERINGS AND THOSE WHO ENGAGE IN THE SECURITIES BUSINESS

[Appeared as Ch 17, 1973 IDR]
[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
DEFINITIONS AND ADMINISTRATION

191—50.1(502) Definitions. For the purposes of this chapter, the definitions in Iowa Code chapter 502 and the following definitions shall apply unless the context otherwise requires:

"Act" means Iowa Code chapter 502, the Iowa Uniform Securities Act (Blue Sky Law).

"Administrator" means the commissioner of insurance or the deputy administrator appointed under Iowa Code section 502.601.

"CCH NASAA Reports" means the official statements of policy of the North American Securities Administrators Association, Inc., printed by Commerce Clearing House, the official reporter for NASAA.

"CRD" means the Central Registration Depository.

"CSRU" means the Iowa child support recovery unit.

"FDIC" means the Federal Deposit Insurance Corporation.

"Form ADV" means Uniform Application for Investment Adviser Registration.

"Form ADV-H" means Notice of Hardship Application for Investment Adviser Registration.

"Form ADV-W" means Notice of Withdrawal from Registration as Investment Adviser.

"Form BD" means Uniform Application for Broker-Dealer Registration.

"Form BDW" means Uniform Request for Broker-Dealer Withdrawal.

"Form 1CP" means Agricultural Cooperative Notice of Sales of Notes or Evidences of Indebtedness.

"Form D" means Notice of Sale of Securities Pursuant to Regulation D, Section 4(6), and/or Uniform Limited Offering Exemption, and includes the Appendix.

"Form F-7" means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers offered for cash upon the exercise of rights granted to existing security holders.

"Form F-8" means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers to be issued in exchange offers or a business combination.

"Form F-9" means Registration Statement Under the Securities Act of 1933, for registration of certain investment grade debt or investment grade preferred securities of certain Canadian issuers.

"Form F-10" means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers.

"Form NF" means Uniform Investment Company Notice Filing.

"Form S-1" means Registration Statement Under the Securities Act of 1933, for registration of securities for which no other form is authorized or prescribed.

"Form SB-2" means Registration Statement Under the Securities Act of 1933, for registration of securities to be sold to the public by small business issuers.

"Form U-1" means Uniform Application to Register Securities.

"Form U-2" means Uniform Consent to Service of Process.

"Form U-2A" means Uniform Corporate Resolution.

"Form U-4" means Uniform Application for Securities Industry Registration or Transfer.

"Form U-5" means Uniform Termination Notice for Securities Industry Registration.

"Form U-6" means Uniform Disciplinary Action Reporting Form.

"Form U-7" means Small Corporate Offering Registration Form.

"Form USR-1" means Investment Company Report of Sales.

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

"IARD" means the Investment Advisory Registration Depository.

"Immediate family" includes 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" includes any other person who is supported, directly or indirectly, to a material extent by an agent.

"Investment contract" as used in Iowa Code section 502.102(28) includes:

1. Any investment in a common enterprise with the expectation of profit to be derived through the essential managerial efforts of someone other than the investor.

(1) "Common enterprise" in this definition means an enterprise in which the fortunes of the investor are tied to the efficacy of the efforts and successes of those seeking the investment or of a third party.

(2) "Profit" in this definition includes income or a return on the investment, including a fixed rate of return, dividends, other periodic payments, or the increased value of the investment; or

2. Any investment by which an offeree furnishes initial value to an offerer, and a portion of this initial value is subjected to the risks of the enterprise, and the furnishing of the initial value is induced by the offerer's promises or representations which give rise to a reasonable understanding that a valuable benefit of some kind over and above the initial value will accrue to the offeree as a result of the operation of the enterprise, and the offeree does not exercise practical and actual control over the managerial decisions of the enterprise.

"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.

"NASAA" means the North American Securities Administrators Association, Inc.

"NASD" means the National Association of Securities Dealers.

"NASDAQ" means the NASDAQ Stock Market.

"NCUA" means the National Credit Union Association.

"NSMIA" means the National Securities Markets Improvement Act of 1996, Public Law 104-290.

"NYSE" means the New York Stock Exchange.

"OTC" means over the counter.

"SAI" means Statement of Additional Information.

"SEC" means the United States Securities and Exchange Commission as established pursuant to 15 U.S.C. Section 78(d).

"SOIF" means Solicitation of Interest Form.

This rule is intended to implement Iowa Code section 502.605(1).

191—50.2(502) Cost of audit or inspection.

50.2(1) A broker-dealer or investment adviser may be assessed the greater of a flat fee of $100 or the costs of salaries, travel, lodging, and meals directly attributable to an audit or inspection made pursuant to Iowa Code section 502.411(4). The assessment of costs of salaries, travel, lodging, and meals, if any, shall be determined in accordance with the department of administrative services (DAS) state accounting enterprise Accounting Policy and Procedures Manual in effect at the time of the audit or inspection.

50.2(2) The administrator shall notify the broker-dealer or investment adviser of the expenses attributable to the audit or inspection as soon as practicable.

50.2(3) Assessments collected by the administrator pursuant to this rule shall be remitted to the state treasury.

This rule is intended to implement Iowa Code section 502.411(4).

191—50.3(502) Interpretative opinions or no-action letters. Interested persons may request the administrator to issue an interpretative opinion pursuant to Iowa Code section 502.605(4). These requests will be answered by means of a no-action letter. Requests for confirmation of the availability of an exemption shall be answered in the same manner. The following procedure is recommended for the submission of such requests:

50.3(1) The request should be in writing and include the factual situation involved, a citation to the applicable part of the rule or statute, and the question sought to be answered. Any disclosure or informational materials which pertain to the issue should also be filed.

50.3(2) The administrator, or any person delegated under Iowa Code section 502.601(1), may respond to the request by determining to take or not to take a no-action position or by declining to reach a determination due to insufficient facts, conflicting case or administrative law or such other reasons as the administrator's discretionary power allows.

50.3(3) All no-action determinations shall be based upon the representations made by the requesting party in the letter and information filed, since any different facts or conditions might require a different conclusion. The no-action letter shall express the division's position on enforcement action only and shall not purport to express any legal conclusion on the questions presented. No determination shall take a position on whether or not any disclosure materials satisfactorily comply with the antifraud and civil liability sections of the Act.

50.3(4) A no-action determination issued under this rule may be provided to interested persons for a filing fee of $100.

This rule is intended to implement Iowa Code section 502.605(4).

191—50.4 to **50.9** Reserved.

DIVISION II
REGISTRATION OF BROKER-DEALERS AND AGENTS

191—50.10(502) Broker-dealer registrations, renewals, amendments, succession, and withdrawals.

50.10(1) An applicant for an initial registration to conduct business as a broker-dealer must:

a. File a current Form BD. If the applicant is a member of NASD, Form BD shall be filed with CRD. If the applicant is not a member of NASD, Form BD shall be signed and notarized and filed with the administrator;

b. File with the administrator copies of the applicant's most recent audited financial statements prepared by an independent certified public accountant in accordance with generally accepted accounting principles and including, at a minimum, a balance sheet, income statement and net capital calculation;

c. Pay a $200 filing fee. If the applicant is a member of NASD, the fee shall be remitted to the CRD. If the applicant is not a member of NASD, the fee shall be remitted to the administrator; and

d. File with the administrator a completed Iowa Broker-Dealer Affidavit form including:

(1) A signed and notarized statement indicating that the applicant engaged in no securities transactions with persons in Iowa prior to registration or, if applicable, identifying all past and current accounts of persons in Iowa; and

(2) A signed consent to service of process pursuant to Iowa Code section 502.611. The form may be obtained from the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066; via E-mail at iowa.sec@iid.state.ia.us; or from the division Web site at http://www.iid.state.ia.us/division/securities.

50.10(2) No application for initial registration will be deemed complete for purposes of Iowa Code section 502.406(3) until the applicant has been approved as a member of NASD.

50.10(3) An applicant that is a member of the NASD and that seeks renewal of a broker-dealer registration shall comply with the renewal time frames established by the NASD for renewal on the CRD system and shall:

a. File with CRD an updated Form BD;

b. Pay to the CRD a $200 renewal filing fee.

50.10(4) An applicant that is not a member of the NASD and that seeks renewal of a broker-dealer registration shall by November 30 of each year:

a. File with the administrator an updated Form BD, manually signed and notarized;

b. File with the administrator the renewal applicant's most recent audited financial statements if they were not previously submitted to the administrator pursuant to subrule 50.10(1);

c. Pay a $200 renewal filing fee, which shall be remitted to the administrator.

50.10(5) Failure to comply with the requirements of subrule 50.10(3) or 50.10(4) shall be deemed a request for withdrawal of the broker-dealer registration, and the registration will be terminated as of December 31 of the renewal year.

50.10(6) A registered broker-dealer that is an NASD member shall submit a withdrawal request by filing an accurate and complete Form BDW with CRD. A registered broker-dealer that is not an NASD member shall submit a withdrawal request by filing an accurate and complete Form BDW with the administrator.

50.10(7) For purposes of Iowa Code section 502.406(2), a correcting amendment to the information or a record contained in either an initial or renewal application shall be considered to be filed "promptly" with the administrator if filed within 30 days of the event necessitating the correcting amendment.

50.10(8) Succession and change in registration.

a. In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, a broker-dealer shall file all applicable amendments to Form BD.

b. In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, a broker-dealer shall file a new application for registration pursuant to subrule 50.10(1). The filing must include the fee pursuant to paragraph 50.10(1)*"c"* and registration fees for all Iowa-registered agents.

c. In the case of a change in name, a broker-dealer shall file all applicable amendments to Form BD.

50.10(9) Upon the administrator's oral or written request, a broker-dealer shall provide to the administrator the broker-dealer's most recent financial reports, audited or unaudited, within two business days of the request. A broker-dealer may utilize express mail delivery or transmission via electronic means to comply with a request pursuant to this subrule. Financial reports not received by the filing deadline are subject to a late fee of $50 per day beyond the filing deadline, not to exceed an aggregate penalty of $500. Imposition of the late fee is not a reportable event. In the event of the broker-dealer's continued noncompliance, the administrator may also pursue sanctions authorized by Iowa Code section 502.412.

This rule is intended to implement Iowa Code section 502.411(2).

191—50.11(502) Principals. Every registered broker-dealer shall have at least two officers or partners registered with NASD as principals, appropriate to the function(s) to be performed.

This rule is intended to implement Iowa Code section 502.406.

191—50.12(502) Agent and issuer registrations, renewals and amendments.

50.12(1) Agent registration.

a. An applicant for registration as an Iowa-registered agent of an NASD or non-NASD member broker-dealer shall:

(1) Pass one of the following NASD examinations: Series 1, 2, 6, 7, 11, 17, 22, 24, 26, 39, 40, 52, 53, or 62. In the event that an applicant for registration as an agent has received a waiver by the NASD of an NASD examination otherwise required by this paragraph, the NASD waiver will be accepted in lieu of the examination requirement;

(2) Pass the NASD Series 63 or Series 66 examination;

(3) File an accurate and complete Form U-4 with CRD; and

(4) Pay a $30 filing fee to NASD if applying for registration as an agent of an NASD member broker-dealer, or to the administrator if applying for registration as an agent of a non-NASD member broker-dealer.

b. An applicant may file with the administrator a written request for waiver of the examination requirement contained in paragraph *"a"* pursuant to rule 191—4.21(17A), et seq. A waiver will be considered for an applicant with ten years of continuous experience in the securities industry. A waiver of the Series 63 examination will not be granted.

50.12(2) No application for an agent registration shall be considered for approval until all requirements of subrule 50.12(1), as applicable, are met. In the administrator's discretion, an applicant may be required to provide additional information regarding any aspect of the application. The application shall be considered incomplete until any such additional information is provided.

50.12(3) Renewals, amendments, and withdrawal requests.

a. A registered agent of an NASD member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to CRD. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

b. A registered agent of a non-NASD member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to the administrator. A withdrawal request shall be made by filing an accurate and complete Form U-5 with the administrator.

50.12(4) An issuer seeking to employ persons as agents of the issuer within the meaning of Iowa Code section 502.102(2) must apply in writing to the administrator for such authority. The application shall include:

a. A statement of the issuer's intent to employ agents for the sale of its securities;

b. The name, address, social security number, and proof of satisfaction of subrule 50.12(1) for each agent;

c. A complete description of the subject securities;

d. A complete and accurate Form U-4; and

e. A $30 filing fee.

This rule is intended to implement Iowa Code section 502.406.

191—50.13(502) Agent continuing education requirements. Every registered agent shall comply with all applicable continuing education requirements adopted by NASD, NYSE, or any other self-regulatory agency. Failure to comply with any such requirements may be a basis for discipline pursuant to Iowa Code section 502.412(4)*"n."*

This rule is intended to implement Iowa Code section 502.411(8).

191—50.14(502) Broker-dealer record-keeping requirements.

50.14(1) Unless otherwise provided by an SEC order, each broker-dealer registered or required to be registered under the Act shall make, maintain and preserve books and records in compliance with SEC Rules 17a-3 (17 CFR 240.17a-3), 17a-4 (17 CFR 240.17a-4), 15c2-6 (17 CFR 240.15c2-6) and 15c2-11 (17 CFR 240.15c2-11).

50.14(2) To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violating this rule to the extent that the violation results solely from the broker-dealer's compliance with the amended rule.

This rule is intended to implement Iowa Code section 502.411(3).

191—50.15(502) Broker-dealer minimum financial requirements and financial reporting requirements.

50.15(1) Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rules 15c3-1 (17 CFR 240.15c3-1), 15c3-2 (17 CFR 240.15c3-2), and 15c3-3 (17 CFR 240.15c3-3).

50.15(2) Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rule 17a-11 (17 CFR 240.17a-11) and shall file with the administrator copies of notices of financial deficiencies, as required under SEC Rule 17a-11 (17 CFR 240.17a-11).

50.15(3) To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violations resulting solely from the broker-dealer's compliance with the amended rules.

This rule is intended to implement Iowa Code section 502.411(2).

191—50.16(502) Dishonest or unethical practices in the securities business.

50.16(1) Dishonest or unethical business practices by any person in the securities business, other than an agent, investment adviser, investment adviser representative, or federal covered investment adviser, as prohibited pursuant to Iowa Code section 502.412(4)*"m"* include, but are not limited to, the following:

a. Engaging in any unreasonable and unjustifiable delay in delivering securities purchased by any customers or paying, upon request, free credit balances reflecting completed transactions of any customers;

b. Inducing in a customer's account trading which is excessive in size or frequency relative to the financial resources and character of the account;

c. Recommending to a customer the purchase, sale or exchange of any securities without reasonable grounds to believe that such transaction or recommendation is suitable for the customer based upon reasonable inquiry concerning the customer's investment objectives, financial situation and needs, and any other relevant information known by the broker-dealer;

d. Executing a transaction on behalf of a customer without authorization;

e. Exercising any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time or price for executing the orders;

f. Executing any transaction in a margin account without securing from the customer a properly executed written margin agreement prior to the initial transaction in the account;

g. Failing to segregate customers' free securities or securities held in safekeeping;

h. Hypothecating a customer's securities without having a lien on them unless the broker-dealer secures from the customer a properly executed written consent promptly after the initial transaction, except as otherwise permitted by SEC rules;

i. Entering into a transaction with or for a customer at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit;

j. Failing to furnish on or before the transaction confirmation date a final prospectus, or, if a final prospectus is not available, a preliminary prospectus together with additional documents which include all information that would be set forth in the final prospectus, to a customer purchasing securities in an offering registered pursuant to Iowa Code section 502.303 or 502.304 or that is subject to a notice filing made pursuant to Iowa Code section 502.302. If the offering is not registered, the broker-dealer shall furnish those disclosure documents that are customarily available;

k. Charging unreasonable and inequitable fees for services performed, including miscellaneous services such as collecting moneys due for principal, dividends or interest, exchange or transfer of securities, appraisals, safekeeping, custody of securities or other services regarding the securities business;

l. Offering to buy from or sell to any person any security at a stated price unless the broker-dealer is prepared to purchase or sell the security at the stated price and under the conditions as stated at the time of the offer to buy or sell the security;

m. Representing that a security is being offered to a customer "at the market" or a price relevant to the market price unless the broker-dealer knows or has reasonable grounds to believe that a market for the security exists other than that made, created or controlled by the broker-dealer, or by any person for whom the broker-dealer is acting or with whom the broker-dealer is associated in the distribution, or any person controlled by, controlling or under common control with such broker-dealer;

n. Effecting any transaction in, or inducing the purchase or sale of, any security by any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, including but not limited to:

(1) Effecting any transaction in a security involving no change in the beneficial ownership thereof;

(2) Entertaining an order for the purchase or sale of any security knowing that an order or orders of substantially the same size have been or will be entered by or for the same or different parties at substantially the same time and price for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance regarding the market for the security. Nothing

in this subparagraph shall prohibit a broker-dealer from entering bona fide agency cross transactions for the broker-dealer's customers;

(3) Effecting, alone or with one or more persons, a series of transactions in any security which creates actual or apparent active trading in a security or raising or depressing the price of the security for the purpose of inducing the purchase or sale of the security by others;

o. Guaranteeing a customer against loss in any securities account of the customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for the customer;

p. Publishing or circulating, or causing to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind purporting to report any transaction as a purchase or sale of any security unless the broker-dealer believes that the transaction was a bona fide purchase or sale of such security, or purporting to quote the bid price or asked price for any security unless the broker-dealer believes that the quotation represents a bona fide bid for or offer of such security;

q. Using any advertising or sales presentation in a deceptive or misleading fashion including but not limited to a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure or flyer, or display by words, pictures, graphs or other medium designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

r. Failing to disclose that the broker-dealer is controlled by, controlling, affiliated with or under common control of the issuer of any security before entering into any contract with or for a customer for the purchase or sale of the security. The existence of any control or affiliation shall be disclosed to the customer in writing prior to completion of the transaction;

s. Failing to make a bona fide public offering of all of the securities allotted to a broker-dealer for distribution, whether the securities were acquired by the broker-dealer as an underwriter, as a selling group member, or from a member participating in the distribution as an underwriter or selling group member;

t. Failing or refusing to furnish a customer, upon reasonable request, information to which the customer is entitled or to respond to a formal written request or complaint from the customer;

u. Failing or refusing to provide information requested in writing by the administrator within 14 days or a later time as prescribed by the administrator;

v. Extending credit to a customer in violation of the Securities Exchange Act of 1934 or the regulations of the Federal Reserve Board;

w. Engaging in acts or practices enumerated in rule 191—50.100(502);

x. Failing in the solicitation of a sale or purchase of an OTC non-NASDAQ security to promptly provide, upon the customer's request, the most current prospectus, the most recent periodic report filed pursuant to Section 13 of the Securities Exchange Act of 1934, or any other available research reports;

y. Marking any order tickets or confirmations as unsolicited when the transaction is solicited;

z. Failing to provide each customer, on no greater than a quarterly basis, a statement of account that, for all OTC non-NASDAQ equity securities in the account for which the firm has been a market maker during the reportable period, contains a value for each security based on the closing market bid on a date certain for any month in which activity has occurred in a customer's account;

aa. Failing to comply with any applicable provision of the NASD Conduct Rules or any applicable fair practice or ethical standard promulgated by the SEC or by a self-regulatory organization approved by the SEC; and

bb. Engaging in or aiding in "boiler-room" operations or high-pressure tactics in connection with the promotion of speculative offerings or "hot issues" by means of an intensive telephone campaign or unsolicited calls to persons not known by, nor having an account with, the agent or broker-dealer represented by the agent, where the prospective purchaser is encouraged to make a hasty decision to buy, irrespective of the purchaser's investment needs and objectives.

50.16(2) Dishonest or unethical practices by an agent in the securities business as prohibited pursuant to Iowa Code section 502.412(4)*"m"* include, but are not limited to, the following:

a. Lending money or securities to or borrowing money or securities from a customer or acting as a custodian for money, securities, or an executed stock power of a customer unless the customer is a member of the agent's immediate family and the act or practice is approved in advance by the agent's supervisory personnel;

b. Effecting securities transactions not recorded on the regular books or records of the broker-dealer the agent represents unless the transactions are authorized in writing by the broker-dealer prior to executing the transaction;

c. Establishing or maintaining an account containing fictitious information for the purpose of executing transactions otherwise prohibited;

d. Sharing, directly or indirectly, in profits or losses in any customer account without the written authorization of the customer and the broker-dealer the agent represents;

e. Dividing or otherwise splitting the agent's commissions, profits, or other compensation from the purchase or sale of securities with any person who is not registered as an agent for the same broker-dealer or for a broker-dealer under direct or indirect common control;

f. Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds $250 in a calendar year. A gift accepted by an immediate family member from an unrelated customer shall be included in the aggregate limit. An agent shall not solicit or accept from a customer a gift transferred through a relative or third party to the agent's benefit that would have the effect of evading this paragraph;

g. Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer;

h. Evading or otherwise negating the requirements of paragraph 50.16(2)*"a," "f"* or *"g"* by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An agent is not in violation of this paragraph if the agent has made a bona fide termination of the customer relationship and conducted no securities-related business or other business for a period of three years with the customer; and

i. Engaging in conduct specified in subrule 50.16(1), paragraphs *"b"* to *"f," "i," "j," "n"* to *"q," "u,"* and *"w"* to *"aa."*

j. Engaging in conduct deemed dishonest or unethical in rule 191—50.54(502).

This rule is intended to implement Iowa Code section 502.412(4)*"m."*

191—50.17(502) Rules of conduct.

50.17(1) Each broker-dealer, after executing and before completing each transaction with its customer, shall give or send the customer a written confirmation. A broker-dealer not registered pursuant to the Securities Exchange Act of 1934 shall provide a written confirmation including, at a minimum:

a. A description of the security purchased or sold, the date of the transaction, the price at which the security was purchased or sold and any commission charged;

b. A statement as to whether the broker-dealer was acting for its own account, as the agent for the customer, as the agent for some other person, or as the agent for both the customer and some other person;

c. When the broker-dealer is acting as an agent for the customer, the name of the person from whom the security was purchased or to whom it was sold or the fact that such information will be furnished upon the customer's request.

50.17(2) A broker-dealer registered pursuant to the Securities Exchange Act of 1934 shall comply with all requirements of the Securities Exchange Act of 1934 and its implementing rules regarding written confirmations.

50.17(3) Each broker-dealer shall establish written supervisory procedures and a system for applying those procedures which may reasonably be expected to prevent and detect any violations of Iowa Code chapter 502, its implementing rules, and any orders issued pursuant to it. Each broker-dealer shall

designate and qualify a number of supervisory employees reasonable in relation to the number of its registered agents, offices, and transactions in Iowa.

50.17(4) Each broker-dealer whose principal office is located in Iowa shall have at least one partner, officer or registered agent employed on a full-time basis at its principal office.

This rule is intended to implement Iowa Code sections 502.411(3) and 502.412(4)*"i."*

191—50.18(502) Limited registration of Canadian broker-dealers and agents.

50.18(1) A Canadian broker-dealer may register under this rule if the broker-dealer:

a. Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

b. Files with the administrator a consent to service of process on Form U-2;

c. Is registered as a broker-dealer and is in good standing in the jurisdiction from which the broker-dealer is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof;

d. Is a member of a self-regulatory organization or stock exchange in Canada; and

e. Pays a $200 filing fee.

50.18(2) An agent representing a Canadian broker-dealer registered under this rule in effecting transactions in securities in Iowa may register under this rule if the agent:

a. Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

b. Files with the administrator a consent to service of process;

c. Is registered and is in good standing in the jurisdiction from which the agent is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof; and

d. Pays a $30 filing fee.

50.18(3) A Canadian broker-dealer that is resident in Canada and has no office or other physical presence in Iowa may, provided that the broker-dealer is registered under this rule, effect transactions in Iowa:

a. With or for a person from Canada temporarily residing in Iowa with whom the Canadian broker-dealer had a bona fide broker-dealer-client relationship before the person entered the United States;

b. With or for a person from Canada currently residing in Iowa whose transactions are in a self-directed, tax-advantaged retirement plan in Canada of which the person is the holder or contributor; or

c. With or through:

(1) The issuers of the securities involved in the transactions;

(2) Other registered broker-dealers;

(3) Banks, savings institutions, trust companies, insurance companies, or investment companies as the term is defined in the Investment Company Act of 1940;

(4) Pension or profit-sharing trusts; or

(5) Other financial institutions or institutional investors, whether acting on their own behalf or as trustees.

50.18(4) An agent registered pursuant to subrule 50.18(2) representing a Canadian broker-dealer registered pursuant to subrule 50.18(1) may effect all securities transactions that the broker-dealer is authorized by subrule 50.18(3) to effect.

50.18(5) If no denial order is in effect and no proceeding is pending pursuant to Iowa Code section 502.304, a registration filed pursuant to this rule becomes effective on the forty-fifth day after an application is filed, unless otherwise provided by order of the administrator.

50.18(6) A Canadian broker-dealer registered under this rule shall:

a. Maintain provincial or territorial registration and membership in a self-regulatory organization or stock exchange and remain in good standing in each;

b. Provide, upon the administrator's request, all books and records relating to its business in Iowa as a broker-dealer;

c. Promptly inform the administrator of any criminal action taken against the broker-dealer or of any finding or sanction imposed on the broker-dealer as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct; and

d. Disclose in writing to each of the broker-dealer's clients in Iowa that the broker-dealer and its agents are not subject to the full regulatory requirements of the Act.

50.18(7) An agent of a Canadian broker-dealer registered under this rule shall:

a. Maintain the agent's provincial or territorial registration and remain in good standing; and

b. Promptly inform the administrator of any criminal action taken against the agent or of any finding or sanction imposed on the agent as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct.

50.18(8) Renewal applications for Canadian broker-dealers and agents under this rule must be filed before December 1 each year and may be made by filing with the administrator the most recent renewal application, if any, filed in the jurisdiction in which the broker-dealer has its principal office or, if no such renewal application is required, the most recent application filed pursuant to paragraph 50.18(1)*"a"* or 50.18(2)*"a."*

50.18(9) Every applicant for registration or renewal registration pursuant to this rule shall pay the applicable fee for broker-dealers and agents as set forth in Iowa Code section 502.410.

50.18(10) A Canadian broker-dealer or agent registered under this rule and in compliance with paragraph 50.18(3)*"c"* is exempt from all the requirements of the Act, except for the antifraud sections and the requirements set out in this rule.

50.18(11) All transactions in securities effected between Canadian broker-dealers or agents registered under this rule and Canadian persons meeting the requirements of paragraph 50.18(3)*"a"* or *"b"* are exempt from Iowa Code sections 502.301 and 502.504.

This rule is intended to implement Iowa Code section 502.401(4).

191—50.19(502) Brokerage services by national and state banks.

50.19(1) A bank may, without registering as a broker-dealer, effect:

a. Transactions pursuant to Iowa Code section 502.102(4)*"c"*; or

b. Transactions permitted by order of the administrator.

50.19(2) A bank that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

a. Provide bank customers and the public with a telephone number of the broker-dealer and provide telephone facilities on bank premises for customers and members of the public to use in contacting the broker-dealer;

b. Distribute literature to bank customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.19(4);

c. Provide broker-dealer account applications to bank customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.19(4), in the form prescribed by subrule 50.19(5), shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application and attachment must be signed by the applicant. The bank may mail the completed account applications to a broker-dealer;

d. Assist bank customers wishing to transfer funds into and out of their bank accounts for securities transactions; and

e. Provide mailers to bank customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

50.19(3) A bank that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

a. Any bank employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

(1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1)*"a"*;

(2) Has passed the NASD Series 63 or Series 66 examination;

(3) Is registered with NASD; and

(4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

b. If the broker-dealer provides securities services in an area of public access on the bank premises in which banking services are not provided, the bank requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and banking services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

c. The bank receives only the following types of compensation from the broker-dealer:

(1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7)*"b"*;

(2) An administrative fee;

(3) Payments for compensation of employees jointly employed by the bank and the broker-dealer; and

(4) Lease payments.

50.19(4) A bank attempting to effect and effecting securities transactions pursuant to a contract with an Iowa-registered broker-dealer may distribute advertisements or promotional materials without registering as a broker-dealer if the advertisements or promotional materials clearly and prominently:

a. Identify the broker-dealer;

b. State in bold typeface that securities transactions and related earnings or profits are not insured by the FDIC;

c. State that the securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the bank; and

d. State that the bank and the broker-dealer are separate organizations.

50.19(5) The following or a similar statement printed in bold typeface and capital letters shall satisfy the disclosure requirements of subrule 50.19(4): [NAME OF BROKER-DEALER] IS NOT A BANK, AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY BANK NOR ARE THEY INSURED BY THE FDIC.

50.19(6) The disclosure requirements of subrule 50.19(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

50.19(7) A bank shall not engage in the following securities activities:

a. Distribute prospectuses to bank customers or to members of the public regarding securities unless done so:

(1) In the exercise of trust functions permitted to banks;

(2) Pursuant to registration as a broker-dealer; or

(3) In the performance of securities activities as permitted by subrule 50.19(1), 50.19(2), or 50.19(3);

b. Allow registered joint bank and broker-dealer employees to split commissions or other transaction-related remuneration received from customers with unregistered bank employees;

c. Transmit account statements, confirmations, or other broker-dealer communications to bank customers or members of the public unless the communications contain a disclosure statement as required by subrule 50.19(4);

d. Permit bank employees who are not registered securities agents of the broker-dealer to receive or transmit orders to the broker-dealer from customers or the public, except as permitted by subrule 50.19(1); and

e. Permit bank employees who are not registered agents of the broker-dealer to perform securities functions directly involving customer contact, except as provided in subrules 50.19(1) and 50.19(2).

This rule is intended to implement Iowa Code sections 502.102(4)*"c"* and 502.401.

191—50.20(502) Broker-dealers having contracts with national and state banks.

50.20(1) A broker-dealer engaging in securities activities with banks as permitted by subrules 50.19(2) and 50.19(3) shall maintain for three years and make available to the administrator upon request the following records:

a. Copies of all advertisements and promotional literature disseminated by the bank and broker-dealer regarding securities services and products offered by the broker-dealer to bank customers and the public;

b. Copies of each contract executed between the bank and the broker-dealer which propose to sell securities to bank customers or the public;

c. Copies of new account forms to be completed by bank customers or members of the public who open an account with the broker-dealer;

d. A list of every bank employee who is a registered securities agent of the broker-dealer and the employee's social security number and CRD number; and

e. Copies of compliance and procedures manuals regarding the securities activities of the bank.

50.20(2) In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a bank as permitted by subrules 50.19(2) and 50.19(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4)*"c"* and 502.401.

191—50.21(502) Brokerage services by credit unions, savings banks, and savings and loan institutions.

50.21(1) A credit union, savings bank, or savings and loan institution may, without registering as a broker-dealer, effect:

a. Transactions pursuant to Iowa Code section 502.102(4)*"c"*; and

b. Transactions permitted by order of the administrator.

50.21(2) A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

a. Provide customers and the public with a telephone number of the broker-dealer and provide telephone facilities on its premises for customers and members of the public to use in contacting the broker-dealer;

b. Distribute literature to its customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.21(4);

c. Provide broker-dealer account applications to its customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.21(4) shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application and attachment must be signed by the applicant. The credit union, savings bank, or savings and loan institution may mail the completed account applications to a broker-dealer;

d. Assist its customers wishing to transfer funds into and out of their accounts for securities transactions; and

e. Provide mailers to its customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

50.21(3) A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

a. Any credit union, savings bank, or savings and loan institution employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

(1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1)*"a"*;

(2) Has passed the NASD Series 63 or Series 66 examination;

(3) Is registered with NASD; and

(4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

b. If the broker-dealer provides securities services in an area of public access on the credit union, savings bank, or savings and loan institution premises in which credit union, savings bank, or savings and loan institution services are not provided, the credit union, savings bank, or savings and loan institution requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and credit union, savings bank, or savings and loan institution services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

c. The credit union, savings bank, or savings and loan institution receives only the following types of compensation from the broker-dealer:

(1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7)*"b"*;

(2) An administrative fee;

(3) Payments for compensation of employees jointly employed by the credit union, savings bank, or savings and loan institution and the broker-dealer; and

(4) Lease payments.

50.21(4) Credit unions, savings banks, and savings and loan institutions attempting to effect and effecting securities transactions under contracts with Iowa-registered broker-dealers may distribute advertisements or promotional materials without registering as broker-dealers if the advertisements or promotional materials clearly and prominently:

a. Identify the broker-dealer.

b. Disclose in bold print that securities transactions and related earnings or profits are not insured by:

(1) The FDIC, in the case of savings banks and savings and loan institutions, or

(2) The NCUA, in the case of credit unions.

c. Disclose that securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the credit union, savings bank, or savings and loan institution.

d. Disclose that the credit union, savings bank, or savings and loan institution and the broker-dealer are separate organizations.

50.21(5) The following or a similar statement in bold print and capital letters will satisfy the disclosure requirements of subrule 50.21(4): [NAME OF BROKER-DEALER] IS NOT A [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION], AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION] NOR ARE THEY INSURED BY THE [FDIC OR NCUA].

50.21(6) The disclosure requirements of subrule 50.21(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

50.21(7) Credit unions, savings banks, and savings and loan institutions shall not:

a. Distribute prospectuses for securities to customers or to members of the public except:

(1) In the exercise of trust functions permitted to them;

(2) Pursuant to registration as a broker-dealer; or

(3) In the performance of securities activities as permitted by subrules 50.21(1) to 50.21(3); or

b. Engage in any of the activities proscribed if performed by an unregistered bank by paragraphs 50.19(7)*"b"* to *"e."*

This rule is intended to implement Iowa Code sections 502.102(4)*"c"* and 502.401.

191—50.22(502) Broker-dealers having contracts with credit unions, savings banks, and savings and loan institutions.

50.22(1) A broker-dealer engaging in securities activities with credit unions, savings banks, or savings and loan institutions as permitted by subrules 50.21(2) and 50.21(3) shall maintain for three years and make available to the administrator upon request the following records:

a. Copies of all advertisements and promotional literature disseminated by the credit union, savings bank, or savings and loan institution and the broker-dealer regarding securities services and

products offered by the broker-dealer to credit union, savings bank, or savings and loan institution customers and the public;

b. Copies of each contract executed between the credit union, savings bank, or savings and loan institution and the broker-dealer which proposes to sell securities to credit union, savings bank, or savings and loan institution customers or the public;

c. Copies of new account forms to be completed by credit union, savings bank, or savings and loan institution customers or members of the public who open an account with the broker-dealer;

d. A list of every credit union, savings bank, or savings and loan institution employee who is a registered securities agent of the broker-dealer and the employee's social security number and CRD number; and

e. Copies of compliance and procedures manuals regarding the securities activities of the credit union, savings bank, or savings and loan institution.

50.22(2) In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a credit union, savings bank, or savings and loan institution as permitted by subrules 50.21(2) and 50.21(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4)*"c"* and 502.401.

191—50.23 to **50.29** Reserved.

DIVISION III
REGISTRATION OF INVESTMENT ADVISERS,
INVESTMENT ADVISER REPRESENTATIVES,
AND FEDERAL COVERED INVESTMENT ADVISERS

191—50.30(502) Electronic filing with designated entity.

50.30(1) *Designation.* Pursuant to Iowa Code sections 502.406 and 502.608(3)*"a,"* the administrator designates the IARD operated by the NASD to receive and store filings and collect related fees from investment advisers on behalf of the administrator.

50.30(2) *Use of IARD.* Unless otherwise provided, all investment adviser applications, amendments, reports, notices, related filings and fees required to be filed with the administrator pursuant to the rules promulgated under the Act shall be filed electronically with and transmitted to IARD. The following additional conditions relate to such electronic filings:

a. Electronic signature. When a signature or signatures are required by the particular instructions of any filing to be made through IARD, a duly authorized signatory of the applicant, as required, shall affix the duly authorized signatory's electronic signature to the filing by typing the duly authorized signatory's name in the appropriate fields and submitting the filing to IARD. Submission of a filing in this manner shall constitute irrefutable evidence of legal signature by any individuals whose names are typed on the filing.

b. When filed. Solely for purposes of a filing made through IARD, a document is considered filed with the administrator when all fees are received and the filing is accepted by IARD on behalf of the state.

This rule is intended to implement Iowa Code sections 502.102(8), 502.406 and 502.608(3)*"a."*

191—50.31(502) Investment adviser applications and renewals.

50.31(1) *Investment adviser applications—required filings.* The application for initial registration as an investment adviser shall be made by:

a. Filing Form ADV Part I with IARD;

b. Remitting the $100 filing fee to IARD pursuant to Iowa Code section 502.410(3); and

c. Filing Form ADV Part II with the administrator.

50.31(2) *Investment adviser applications—discretionary filings.* The administrator may require that an application for initial registration also include the following:

a. Financial statements as set forth in paragraph 50.42(1)*"f"* including, but not limited to, a copy of the balance sheet for the last fiscal year and, if the balance sheet is prepared as of a date more than 45 days from the date of the filing of the application, an unaudited balance sheet prepared in accordance with subrule 50.40(7);

b. A copy of the surety bond required pursuant to rule 191—50.41(502), if any; and

c. Any other information necessary for determining whether registration is appropriate.

50.31(3) *Investment adviser renewals—required filings.* Annual renewals by investment advisers shall be made by:

a. Filing an annual renewal registration with IARD; and

b. Remitting the $100 filing fee to IARD as required pursuant to Iowa Code section 502.410(3).

50.31(4) *Investment adviser renewals—discretionary filings.* The administrator may require the filing of a copy of the surety bond, if any, required pursuant to rule 191—50.41(502).

50.31(5) *Completion of filing.* An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by IARD and the administrator.

50.31(6) *Updates and amendments.* The investment adviser is under a continuing obligation to update information provided on Form ADV as follows:

a. An updated Form ADV must be filed with IARD within 90 days of the end of the investment adviser's fiscal year; and

b. Any amendment to Form ADV must be filed with IARD within 30 days of the event causing the required amendment.

50.31(7) *Succession and change in registration.*

a. In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, an investment adviser shall file all applicable amendments to Form ADV.

b. In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, an investment adviser must file a new application for registration pursuant to subrule 50.31(1). The filing must include the fee pursuant to paragraph 50.31(1)*"b"* and registration fees for all Iowa-registered investment adviser representatives.

c. In the case of a change in name, an investment adviser shall file all applicable amendments to Form ADV.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406.

191—50.32(502) Application for investment adviser representative registration.

50.32(1) *Designation.* Pursuant to Iowa Code sections 502.406 and 502.608(3)*"a,"* the administrator designates the CRD operated by the NASD to receive and store filings and collect related fees from investment adviser representatives on behalf of the administrator.

50.32(2) *Initial application.* The application for initial registration as an investment adviser representative made pursuant to Iowa Code section 502.406(1) shall be made by filing Form U-4 with the CRD. The following shall be submitted to the CRD with the application:

a. Proof of compliance by the investment adviser representative with the examination requirements of rule 191—50.33(502); and

b. If applicable, the $30 fee required pursuant to Iowa Code section 502.410(4).

50.32(3) *Annual renewal.* Annual renewals by investment adviser representatives shall be made by:

a. Filing an annual renewal registration with CRD; and

b. If applicable, remitting the $30 filing fee to CRD as required pursuant to Iowa Code section 502.410(4).

50.32(4) *Completion of filing.* An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by the CRD.

50.32(5) *Updates, amendments, withdrawals and terminations.* The investment adviser representative is under a continuing obligation to update information provided on Form U-4 as follows:

a. Any amendment to information provided on Form U-4 must be filed with CRD within 30 days of the event causing the required amendment; and

b. A withdrawal request or termination must be filed with CRD within 30 days of the event causing the necessity of a withdrawal request or termination. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406.

191—50.33(502) Examination requirements.

50.33(1) Except as exempted by subrule 50.33(2), a person applying to be registered as an investment adviser representative shall provide the administrator with proof that the person has obtained a passing score on one of the following examinations:

a. The Series 65 examination as implemented January 1, 2000; or

b. The Series 7 examination and Series 66 examination as implemented January 1, 2000. In the event that an applicant for registration as an investment adviser representative has received a waiver by the NASD of the Series 7 examination otherwise required by this paragraph, the NASD waiver will be accepted in lieu of the examination requirement.

50.33(2) Unless otherwise ordered by the administrator in connection with a violation of the Act, the following individuals shall be exempt from the examination requirements of subrule 50.33(1):

a. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States on or before January 19, 2000.

b. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States after November 1, 2001, provided that the jurisdiction in which the investment adviser or investment adviser representative is registered requires the passage of the examinations in subrule 50.33(1).

c. Any individual who has not been registered as an investment adviser or investment adviser representative in any jurisdiction for a period of two years shall be required to comply with the examination requirements of this rule.

d. Any individual who currently holds one of the following professional designations:

(1) Certified Financial Planner or CFP designation awarded by the Certified Financial Planner Board of Standards, Inc.;

(2) Chartered Financial Consultant (ChFC) designation awarded by The American College, Bryn Mawr, Pennsylvania;

(3) Personal Financial Specialist (PFS) designation administered by the American Institute of Certified Public Accountants;

(4) Chartered Financial Analyst (CFA) designation granted by the Association for Investment Management and Research;

(5) Chartered Investment Counselor (CIC) designation granted by the Investment Counsel Association of America; or

(6) Any other professional designation recognized by order of the administrator.

This rule is intended to implement Iowa Code section 502.412(5).

191—50.34(502) Notice filing requirements for federal covered investment advisers.

50.34(1) *Notice filing.* The notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD on an executed Form ADV. A notice filing of a federal covered investment adviser shall be deemed filed for purposes of this subrule when Form ADV and the fee of $100 required pursuant to Iowa Code section 502.410(5) are received by IARD.

50.34(2) *Portions of Form ADV not yet accepted by IARD.* Until such time, if any, that IARD provides for the filing of Part II of Form ADV, Part II of Form ADV is required to be filed only upon the administrator's request. Part II of Form ADV shall be deemed filed for purposes of this subrule if a

federal covered investment adviser provides Part II of Form ADV to the administrator within five days of any oral or written request.

50.34(3) *Renewal.* The annual renewal of the notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD. The renewal of the notice filing shall be deemed filed for purposes of this subrule when the $100 fee required pursuant to Iowa Code section 502.410(5) is accepted by IARD.

50.34(4) *Updates and amendments.* A federal covered investment adviser must file with IARD any amendments to the federal covered investment adviser's Form ADV.

This rule is intended to implement Iowa Code section 502.405.

191—50.35(502) Withdrawal of investment adviser registration. The application for withdrawal of registration as an investment adviser pursuant to Iowa Code section 502.409 shall be completed on Form ADV-W and filed with IARD.

This rule is intended to implement Iowa Code section 502.409.

191—50.36(502) Investment adviser disclosure statement.

50.36(1) Unless otherwise provided by order, an investment adviser, registered or required to be registered pursuant to Iowa Code section 502.403, shall furnish each advisory client and prospective advisory client with a written disclosure statement. The disclosure statement may be a copy of Part II of the investment adviser's Form ADV, written documents containing no less than the information contained in Part II of Form ADV, or any other form permitted by order of the administrator.

50.36(2) The written disclosure document shall be provided as follows:

a. An investment adviser shall deliver the written disclosure statement required by subrule 50.36(1) to an advisory client or prospective advisory client as follows:

(1) For all investment advisory services other than impersonal investment advisory services, not less than 48 hours prior to entering into an investment advisory contract with the client or prospective client or, alternatively, at the time of entering into the investment advisory contract, provided the advisory client has the right to terminate the contract without penalty within five business days after entering into the contract; and

(2) Without charge, on an annual basis thereafter or, alternatively, within seven days of a written request by the client, if the offer to provide the written disclosure statement upon request is provided to the advisory client in writing.

b. An advisory client receiving impersonal advisory services pursuant to a contract requiring a payment of $200 or more must be given the written offer to provide the written disclosure statement at the time of entering into the contract. An investment adviser is not required to provide the written disclosure statement to an advisory client receiving impersonal advisory services pursuant to a contract requiring a payment of less than $200.

50.36(3) An investment adviser rendering substantially different types of advisory services to different advisory clients may omit information required by Part II of Form ADV from the statement furnished to an advisory client or prospective advisory client if the omitted information applies only to a type of investment advisory service or fee which is not rendered or charged, or is proposed to be rendered or charged, to that client or prospective client.

50.36(4) Nothing in this rule shall relieve any investment adviser from any obligation under any other provision of the Act, its implementing rules, or other state or federal law to disclose any information to the investment adviser's advisory clients or prospective advisory clients.

50.36(5) For purposes of this rule:

a. "Contract for impersonal advisory services" includes any contract relating solely to the provision of investment advisory services:

(1) Through providing written material or making oral statements not purporting to meet the objectives or needs of specific individuals or accounts;

(2) Through issuing statistical information in which no opinion is expressed as to the investment merits of a particular security; or

(3) Any combination of (1) and (2).

b. The act of "entering into an investment advisory contract" does not include an extension or renewal of an investment advisory contract if there is no material change in the terms of the contract to be extended or renewed.

This rule is intended to implement Iowa Code section 502.411(7).

191—50.37(502) Cash solicitation.

50.37(1) Payment of a cash fee, directly or indirectly, by an investment adviser to a solicitor for solicitation activities shall constitute an act, practice, or course of conduct operating as a fraud or deceit upon a person, pursuant to Iowa Code section 502.502(2), if:

a. The solicitor:

(1) Is subject to an order issued by the administrator pursuant to Iowa Code section 502.412(4);

(2) Has been convicted of a felony or within the previous ten years has been convicted of a misdemeanor involving conduct described in Iowa Code section 502.412(4)*"c"*; or

(3) Is found by the administrator to have engaged or has been convicted of engaging in any of the conduct specified in Iowa Code section 502.505, 502.412(4)*"b"* or 502.412(4)*"i"*; has materially aided in violating Iowa Code section 502.412(4)*"d"*; or is subject to an order, judgment, or decree pursuant to Iowa Code section 502.412(4)*"d"* to *"f."*

b. The cash fee is not paid pursuant to a written agreement to which the investment adviser is a party. If the cash fee is paid pursuant to a written agreement, the written agreement must:

(1) Describe the solicitation activities to be engaged in by the solicitor on behalf of the investment adviser and the compensation to be received for the solicitation activities;

(2) Contain an undertaking by the solicitor to perform the solicitor's duties under the agreement in a manner consistent with the instructions of the investment adviser and the provisions of the Act and its implementing rules, as applicable; and

(3) Require that the solicitor, at the time of any solicitation activities for which compensation is paid or is to be paid by the investment adviser, provide the client with a current copy of the investment adviser's written disclosure statement required by subparagraph 50.36(2)*"a"*(2) or SEC Rule 204-3, if applicable, and a separate written disclosure statement as described in subrule 50.37(2). Prior to or upon entering into a written or oral investment advisory contract with a client, the investment adviser shall obtain a signed and dated acknowledgment of receipt by the client of the investment adviser's and solicitor's written disclosure statements. Additionally, the investment adviser shall make a bona fide effort to ascertain whether the solicitor has complied in all aspects with the written agreement, and shall have a reasonable basis for believing that the solicitor has complied.

c. The cash fee is paid to a solicitor:

(1) For solicitation activities regarding anything other than impersonal advisory services; or

(2) Who is a partner, officer, director, or employee of the investment adviser or is a partner, officer, director, or employee of a person who controls, is controlled by, or is under common control with the investment adviser without disclosure of the status of the solicitor as a partner, officer, director, or employee of the investment adviser or other person and of any affiliation between the investment adviser and the solicitor to the client at the time of solicitation or referral.

50.37(2) The separate written disclosure statement required to be furnished pursuant to subparagraph 50.37(1)*"b"*(3) shall contain the following information:

a. The name of the solicitor;

b. The name of the investment adviser;

c. The nature of the relationship, including any affiliation, between the solicitor and the investment adviser;

d. A statement that the solicitor will be compensated for the solicitor's solicitation services by the investment adviser;

e. The terms of such compensation arrangement, including a description of the compensation paid or to be paid to the solicitor; and

f. The amount, if any, the client will be charged for the cost of obtaining the client's account in addition to the advisory fee, and the differential, if any, in advisory fees charged by the investment adviser if the differential is the result of the investment adviser's agreement to compensate the solicitor for soliciting or referring clients.

50.37(3) Nothing in this rule relieves any person of any fiduciary duty or other obligation to which the person may be subject pursuant to contract or law.

50.37(4) For the purpose of this rule:

"Client" includes any prospective client.

"Impersonal advisory services" means investment advisory services provided solely through written materials or oral statements not purporting to meet the objectives or needs of the specific client, statistical information containing no expressions of opinion as to the investment merits of particular securities, or any combination of the foregoing.

"Principal place of business" of an investment adviser means the executive office of the investment adviser from which the officers, partners, or managers of the investment adviser direct, control, and coordinate the activities of the investment adviser.

"Solicitor" means any person who, directly or indirectly, solicits any client for or refers any client to an investment adviser.

50.37(5) An investment adviser shall retain a copy of each written agreement, acknowledgment and solicitor disclosure statement required by this rule in accordance with Iowa Code section 502.411(3) and paragraph 50.42(1)*"o."* However, an investment adviser registered in Iowa whose principal place of business is located outside Iowa shall not be subject to the record maintenance requirements of this subrule and the applicable provisions of paragraph 50.42(1)*"o"* if:

a. The investment adviser is registered or licensed as an investment adviser in the state in which the investment adviser maintains the investment adviser's principal place of business;

b. The investment adviser complies with the applicable books and records requirements of the state in which the investment adviser maintains the investment adviser's principal place of business; and

c. The provisions of this rule would require the investment adviser to maintain books or records in addition to those required by the laws of the state in which the investment adviser maintains the investment adviser's principal place of business.

This rule is intended to implement Iowa Code section 502.502(2).

191—50.38(502) Dishonest or unethical business practices of investment advisers and investment adviser representatives, or fraudulent or deceptive conduct by federal covered investment advisers. An investment adviser, investment adviser representative, or a federal covered investment adviser has a fiduciary duty to act for the benefit of its clients. The federal statutory and regulatory provisions referenced in this rule apply to investment advisers and federal covered investment advisers, to the extent permitted by the NSMIA. This rule applies to federal covered investment advisers to the extent that the alleged conduct is fraudulent, deceptive, or as otherwise prohibited by the NSMIA.

50.38(1) An investment adviser, investment adviser representative, or a federal covered investment adviser shall not engage in dishonest or unethical business practices or fraudulent and deceptive conduct including, but not limited to:

a. Recommending to a client to whom supervisory, management, or consulting services are provided the purchase, sale, or exchange of any security without reasonable grounds to believe that the recommendation is suitable for the client on the basis of information furnished by the client after reasonable inquiry concerning the client's investment objectives, financial situation and needs, and any other information known by the investment adviser;

b. Exercising any discretionary power in placing an order for the purchase or sale of securities for a client without obtaining written discretionary authority from the client within ten business days after the date of the first transaction placed pursuant to discretionary authority, unless the discretionary power relates solely to the price at which, or the time when, an order for a definite amount of a specified security shall be executed, or both;

c. Inducing in a client's account trading that is excessive in size or frequency compared to the financial resources, investment objectives, and character of the account;

d. Placing an order to purchase or sell a security for a client account without authority to do so;

e. Placing an order to purchase or sell a security for a client account upon instruction of a third party without first obtaining a written third-party trading authorization from the client;

f. Borrowing money or securities from a client unless the client is a broker-dealer, an affiliate of the investment adviser, or a financial institution engaged in the business of loaning funds;

g. Loaning money to a client unless the investment adviser is a financial institution engaged in the business of loaning funds or the client is an affiliate of the investment adviser;

h. Misrepresenting to any advisory client, or prospective advisory client, the qualifications of the investment adviser or any employee of the investment adviser, or misrepresenting the nature of the advisory services being offered or fees to be charged for such service, or omitting to state a material fact necessary to make the statements made regarding qualifications, services or fees, in light of the circumstances under which they are made, not misleading;

i. Providing a report or recommendation to any advisory client prepared by someone other than the investment adviser without disclosing that fact. This prohibition does not apply when the investment adviser uses published research reports or statistical analyses to render advice or when an investment adviser orders such a report in the normal course of providing service;

j. Charging a client an unreasonable advisory fee;

k. Failing to disclose to clients in writing before any advice is rendered any material conflict of interest regarding the investment adviser or any of its employees which could reasonably be expected to impair the rendering of unbiased and objective advice including, but not limited to:

(1) Compensation arrangements connected with advisory services to clients which are in addition to compensation from such clients for such services; and

(2) Charging a client an advisory fee for rendering advice when a commission for executing securities transactions pursuant to such advice will be received by the investment adviser or its employees;

l. Guaranteeing a client that a specific result will be achieved (gain or no loss) as a result of the investment adviser's services;

m. Disclosing the identity, affairs, or investments of any client unless required by law to do so, or unless disclosed with the client's consent;

n. Taking any action, directly or indirectly, regarding securities or funds in which any client has any beneficial interest when the investment adviser is in violation of the custody requirements provided by rule 191—50.39(502);

o. Entering into, extending or renewing any investment advisory contract unless such contract is in writing and discloses:

(1) The services to be provided;

(2) The term of the contract;

(3) The advisory fee;

(4) The formula for computing the fee;

(5) The amount of prepaid fee to be returned in the event of contract termination or nonperformance;

(6) Whether the contract grants discretionary power to the investment adviser; and

(7) That no assignment of such contract shall be made by the investment adviser without the consent of the other party to the contract;

p. Failing to establish, maintain, and enforce written policies and procedures reasonably designed to prevent the misuse of material nonpublic information in violation of Section 204A of the Investment Advisers Act of 1940;

q. Entering into, extending, or renewing any advisory contract in violation of Section 205 of the Investment Advisers Act of 1940. This provision applies to all advisers and investment adviser representatives registered or required to be registered under this Act, notwithstanding whether such

adviser or investment adviser representative would be exempt from federal registration pursuant to Section 203(b) of the Investment Advisers Act of 1940;

r. Providing in an advisory contract any condition, stipulation, or provisions which purport to bind any person to waive compliance with any provision of this Act or of the Investment Advisers Act of 1940 or any other practice contrary to Iowa Code section 502.509(12) or Section 215 of the Investment Advisers Act of 1940;

s. Engaging in any act, practice, or course of business which is fraudulent, deceptive, or manipulative in violation of Section 206(4) of the Investment Advisers Act of 1940, regardless of whether the investment adviser or investment adviser representative is not registered or required to be registered pursuant to Section 203 of the Investment Advisers Act of 1940;

t. Engaging in conduct or any act, indirectly or through or by any other person, which is unlawful for such person to do directly under the provisions of this Act, its implementing rules, or order of the administrator;

u. Failing to disclose or providing incomplete disclosure to a client regarding any securities-related activities, or engaging in deceptive practices;

v. Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds $250 in a calendar year. A gift accepted by an immediate family member from an unrelated client shall be included in the aggregate limit. An investment adviser shall not solicit or accept from a client a gift transferred through a relative or third party to the investment adviser's benefit that would have the effect of evading this paragraph;

w. Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer; and

x. Evading or otherwise negating the requirements of paragraph 50.38(1)*"f," "g," "v,"* or *"w"* by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An investment adviser or investment adviser representative will not be in violation of this rule if the investment adviser or investment adviser representative has made a bona fide termination of the client relationship and conducted no securities-related business or other business for a period of three years with the client.

y. Engaging in conduct deemed dishonest or unethical in rule 191—50.54(502).

50.38(2) Except as otherwise provided in subrule 50.38(3), it shall constitute a dishonest or unethical practice within the meaning of Iowa Code section 502.412(4)*"m"* for any investment adviser or investment adviser representative, directly or indirectly, to use any advertisement that does any one of the following:

a. Refers to any testimonial of any kind concerning the investment adviser or investment adviser representative or concerning any advice, analysis, report, or other service rendered by such investment adviser or investment adviser representative.

b. Refers to past specific recommendations of the investment adviser or investment adviser representative that were or would have been profitable to any person, except that an investment adviser or investment adviser representative may furnish or offer to furnish a list of all recommendations made by the investment adviser or investment adviser representative within the immediately preceding period of not less than one year if the advertisement or list also includes both of the following:

(1) The name of each security recommended, the date and nature of each recommendation, the market price at that time, the price at which the recommendation was to be acted upon, and the most recently available market price of each such security.

(2) A legend on the first page in prominent print or type that states that the reader should not assume that recommendations made in the future will be profitable or will equal the performance of the securities in the list.

c. Represents that any graph, chart, formula, or other device being offered can in and of itself be used to determine which securities to buy or sell, or when to buy or sell them; or which represents, directly or indirectly, that any graph, chart, formula, or other device being offered will assist any person in making that person's own decisions as to which securities to buy or sell, or when to buy or sell them,

without prominently disclosing in such advertisement the limitations thereof and the difficulties with respect to the use of any graph, chart, formula or device.

d. Represents that any report, analysis, or other service will be furnished for free or without charge, unless such report, analysis, or other service actually is or will be furnished entirely free and without any direct or indirect condition or obligation.

e. Represents that the administrator has approved any advertisement.

f. Contains any untrue statement of a material fact, or any statement that is otherwise false or misleading.

50.38(3) With respect to federal investment covered advisers, the provisions of this rule apply only to the extent permitted by Section 203A of the Investment Advisers Act of 1940.

50.38(4) For the purposes of this rule, the term "advertisement" shall include any notice, circular, letter, or other written communication addressed to more than one person, or any notice or other announcement in any electronic or paper publication, by radio or television, or by any medium, that offers any one of the following:

a. Any analysis, report, or publication concerning securities.

b. Any analysis, report, or publication that is to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

c. Any graph, chart, formula, or other device to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

d. Any other investment advisory service with regard to securities.

This rule is intended to implement Iowa Code section 502.412(4)*"m."*

191—50.39(502) Custody of client funds or securities by investment advisers.

50.39(1) *Safekeeping required.* An investment adviser registered or required to be registered pursuant to the Act will be deemed to have committed an unlawful and fraudulent, deceptive, or manipulative act, practice or course of business if the investment adviser has custody of client funds or securities unless:

a. The investment adviser promptly notifies the administrator in writing using Form ADV that the investment adviser has or may have custody.

b. A qualified custodian maintains client funds and securities:

(1) In a separate account for each client under each client's name;

(2) In accounts that contain only the investment adviser's client funds and securities under the investment adviser's name as agent or trustee for the clients; or

(3) The client, or the client's designated independent representative, is promptly notified in writing of the qualified custodian's name, address, and the manner in which the funds or securities are maintained when the account is opened and following any changes to the information.

An investment adviser who intends to have custody of client funds or securities but is not able to utilize a "qualified custodian" as defined by paragraph 50.39(3)*"c"* must obtain approval from the administrator prior to taking custody and must comply with all of the applicable provisions of this rule including those provisions that are designated to be performed by a qualified custodian.

c. Account statements are sent:

(1) By a qualified custodian on no less than a quarterly basis to each client, or to the client's designated independent representative, whose funds or securities are kept in custody identifying the amount of funds and of each security in the account at the end of the period and setting forth all transactions in the account during that period. The investment adviser is not required to confirm the receipt of the account statements, but must have a reasonable belief that the qualified custodian is complying with this requirement; or

(2) By the investment adviser on no less than a quarterly basis to each client, or the client's designated independent representative, whose funds or securities are kept in custody identifying the amount of funds and of each security in the account at the end of the period and setting forth all transactions in the account during that period. An independent certified public accountant must verify all client funds and securities by actual examination at least once during each calendar year at a random

time chosen by the accountant without prior notice or announcement to the investment adviser. The investment adviser shall direct the accountant to submit a copy of the auditor's report and financial statements to the administrator within 30 days after the completion of the examination, along with a letter indicating that the accountant examined the funds and securities and describing the nature and extent of the examination. The investment adviser shall also direct the accountant that the accountant is to directly notify the administrator in writing of any finding of a material discrepancy within one business day of the finding. The accountant may provide notice of the discrepancy to the administrator by either first-class mail or by electronic means followed by first-class mail; and

(3) By the investment adviser to each limited partner, member, or other beneficial owner, or the person's independent representative, if the investment adviser is a general partner of a limited partnership or managing member of a limited liability company, or holds a comparable position for another type of pooled investment vehicle.

d. An investment adviser who has custody as defined by subparagraph 50.39(3)*"a"*(3) and has fees directly deducted from client accounts provides the following safeguards:

(1) The investment adviser must obtain written authorization from the client to deduct advisory fees from the account held with the qualified custodian;

(2) Each time a fee is directly deducted from a client account, the investment adviser must concurrently:

1. Send the qualified custodian notice of the amount of the fee to be deducted from the client's account; and

2. Send the client an invoice itemizing the fee. The itemization must provide, at a minimum, the formula used to calculate the fee, the amount of assets under management the fee is based on, and the time period covered by the fee; and

(3) The investment adviser must notify the administrator in writing on Form ADV that the investment adviser intends to use the safeguards provided above.

e. An investment adviser who has custody as defined by subparagraph 50.39(3)*"a"*(4) and who does not meet the exception provided by paragraph 50.39(2)*"c"* complies, in addition to compliance with the safeguards set forth in paragraphs 50.39(1)*"a"* to *"c,"* with the following:

(1) Engages an independent party to review all fees, expenses, and capital withdrawals from the pooled accounts;

(2) Sends to the independent party all invoices and receipts detailing the amount of the fees, expenses, or capital withdrawals and providing the method of calculation so that the independent party can determine that a payment is in accordance with the pooled investment vehicle standards (generally the partnership agreement or membership agreement). The investment adviser shall direct the independent party to forward approval for payment of the invoice to the qualified custodian with a copy to the investment adviser; and

(3) Notifies the administrator in writing on Form ADV that the investment adviser intends to use the safeguards provided above.

For purposes of this paragraph, an "independent party" is a person that is engaged by the investment adviser to act as a monitor of the payment of fees, expenses, and capital withdrawals from the pooled investment; that does not control and is not controlled by or under common control with the investment adviser; and that does not have and has not had within the past two years a material business relationship with the investment adviser.

f. When a trust retains an investment adviser, investment adviser representative, or employee, director or owner of an investment adviser as trustee and the investment adviser acts as the investment adviser to that trust, the investment adviser:

(1) Notifies the administrator in writing that the investment adviser intends to use the safeguards provided in subparagraphs (2) and (3) below. Such notification is required to be given on Form ADV.

(2) Sends to the grantor of the trust, the attorney for the trust if it is a testamentary trust, the cotrustee (other than the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser), or a defined beneficiary of the trust, at the same time that the investment adviser sends any invoice to the qualified custodian, an invoice showing the amount of the trustees' fee

or investment management or advisory fee, the value of the assets on which the fees were based, and the specific manner in which the fees were calculated.

(3) Enters into a written agreement with a qualified custodian which specifies:

1. That the qualified custodian shall not deliver trust securities to the investment adviser, any investment adviser representative, or any employee, director or owner of the investment adviser, nor transmit any funds to the investment adviser, any investment adviser representative or employee, director or owner of the investment adviser, except that the qualified custodian may pay trustees' fees to the trustee and investment management or advisory fees to the investment adviser, provided that:

- The grantor of the trust or attorneys for the trust, if it is a testamentary trust, the cotrustee (other than the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser), or a defined beneficiary of the trust has authorized the qualified custodian in writing to pay the fees;
- The statements for the fees show the amount of the fees for the trustee and, in the case of statements for investment management or advisory fees, show the value of the trust assets on which the fee is based and the manner in which the fee was calculated; and
- The qualified custodian agrees to send to the grantor of the trust, the attorneys for a testamentary trust, the cotrustee (other than the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser), or a defined beneficiary of the trust, at least quarterly, a statement of all disbursements from the account of the trust, including the amount of investment management fees paid to the investment adviser and the amount of trustees' fees paid to the trustee.

2. Except as otherwise set forth in the first bulleted paragraph below, that the qualified custodian may transfer funds or securities, or both, of the trust only upon the direction of the trustee (who may be the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser), whom the investment adviser has duly accepted as an authorized signatory. The grantor of the trust or attorneys for the trust, if it is a testamentary trust, the cotrustee (other than the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser), or a defined beneficiary of the trust, must designate the authorized signatory for management of the trust. The direction to transfer funds or securities, or both, shall only be made:

- To a trust company, bank trust department or brokerage firm independent of the investment adviser for the account of the trust to which the assets relate;
- To the named grantors or to the named beneficiaries of the trust;
- To a third person independent of the investment adviser in payment of the fees or charges of the third person including, but not limited to, the attorney's, accountant's, or qualified custodian's fees for the trust; and taxes, interest, maintenance or other expenses, if there is property other than securities or cash owned by the trust;
- To third persons independent of the investment adviser for any other purpose legitimately associated with the management of the trust; or
- To a broker-dealer in the normal course of portfolio purchases and sales, provided that the transfer is made on a payment-against-delivery basis or a payment-against-trust receipt.

50.39(2) *Exceptions.*

a. Shares of mutual funds. With respect to the shares of an open-end company as it is defined by Section 5(a)(1) of the Investment Company Act of 1940, an investment adviser may use the mutual fund's transfer agent in lieu of a qualified custodian for purposes of complying with subrule 50.39(1).

b. Certain privately offered securities. An investment adviser is not required to comply with subrule 50.39(1) with respect to securities that are:

(1) Acquired from the issuer in a transaction or chain of transactions not involving any public offering;

(2) Uncertificated, and ownership thereof is recorded only on books of the issuer or its transfer agent in the name of the client; and

(3) Transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

This exception is not available with respect to securities held for the account of a limited partnership, limited liability company, or other type of pooled investment vehicle unless the financial statements of the limited partnership, limited liability company, or other type of pooled investment vehicle are audited, the audited financial statements are distributed in compliance with paragraph 50.39(2)*"c,"* and the investment adviser notifies the administrator in writing on Form ADV that the investment adviser intends to comply with this subrule.

c. Limited partnerships subject to annual audit. An investment adviser is not required to comply with paragraph 50.39(1)*"c"* with respect to the account of a limited partnership, limited liability company, or other type of pooled investment vehicle that is subject to audit at least annually and distributes its audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners, members, or other beneficial owners within 120 days of the end of its fiscal year. The investment adviser must notify the administrator in writing on Form ADV that the investment adviser intends to comply with this paragraph.

d. Registered investment companies. An investment adviser is not required to comply with this rule with respect to the account of an investment company registered pursuant to the Investment Company Act of 1940.

e. Beneficial trusts. An investment adviser is not required to comply with this rule or the net worth and bonding requirements of rules 191—50.40(502), 191—50.41(502), and 191—50.43(502) if the investment adviser has custody solely because the investment adviser, investment adviser representative, or employee, director or owner of the investment adviser is a trustee for a beneficial trust and if all of the following conditions are met for each trust:

(1) The beneficial owner of the trust is a parent, a grandparent, a spouse, a sibling, a child or a grandchild of the trustee, including "step" relationships;

(2) The investment adviser provides a written statement to each beneficial owner of the account setting forth a description of the requirements of subrule 50.39(1) and the reasons for noncompliance with the provisions of subrule 50.39(1);

(3) The investment adviser obtains from each beneficial owner a signed and dated statement acknowledging the receipt of the written statement; and

(4) The investment adviser retains a copy of the documents required by subparagraphs 50.39(2)*"e"*(2) and (3) until the account is closed or the investment adviser is no longer trustee.

50.39(3) *Definitions.* For the purposes of this rule:

a. "Custody" means holding, directly or indirectly, client funds or securities, having any authority to obtain possession of client funds or securities, or having the ability to appropriate client funds or securities. "Custody" includes:

(1) Possession of client funds or securities unless received inadvertently and returned to the sender promptly, but in no case later than three business days following inadvertent receipt;

(2) Receipt of checks drawn by clients and made payable to unrelated third parties, the record of which is maintained by the investment adviser in compliance with paragraph 50.42(1)*"v"* unless forwarded to the third party within 24 hours of receipt;

(3) Any arrangement including, but not limited to, a general power of attorney pursuant to which the investment adviser is authorized or permitted to withdraw client funds or securities maintained with a custodian upon the investment adviser's instruction; and

(4) Any capacity including, but not limited to, general partner of a limited partnership, managing member of a limited liability company, a comparable position for another type of pooled investment vehicle, or trustee of a trust that gives the investment adviser or a person supervised by the investment adviser legal ownership of or access to client funds or securities.

b. "Independent representative" means a person who:

(1) Acts as agent for an advisory client including, in the case of a pooled investment vehicle, limited partners of a limited partnership, members of a limited liability company, or other beneficial owners of another type of pooled investment vehicle, and who is by law or contract required to act in the best interest of the advisory client or the limited partners or members, or other beneficial owners;

(2) Does not control, is not controlled by, and is not under common control with the investment adviser; and

(3) Does not have and has not had within the past two years a material business relationship with the investment adviser.

c. "Qualified custodian" means the following independent institutions or entities that are not affiliated with the investment adviser by any direct or indirect common control and have not had a material business relationship with the investment adviser in the previous two years:

(1) A bank or savings association that has deposits insured by the Federal Deposit Insurance Corporation under the Federal Deposit Insurance Act;

(2) A registered broker-dealer holding client assets in customer accounts;

(3) A registered futures commission merchant registered pursuant to Section 4(f)(a) of the Commodity Exchange Act that is holding client funds and security futures or other securities incidental to transactions in contracts for the purchase or sale of a commodity for future delivery and options thereon in customer accounts; and

(4) A foreign financial institution that customarily holds financial assets for its customers, provided that the foreign financial institution keeps the advisory clients' assets in customer accounts segregated from its proprietary assets.

This rule is intended to implement Iowa Code section 502.411(5).

191—50.40(502) Minimum financial requirements for investment advisers.

50.40(1) An investment adviser registered or required to be registered under the Act that has custody of client funds or securities shall maintain at all times a minimum net worth of $35,000 except:

a. An investment adviser that has custody solely due to direct fee deduction and that is also in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"d"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule;

b. An investment adviser having custody solely due to advising pooled investment vehicles and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"e"* or 50.39(2)*"c"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule;

c. An investment adviser having custody solely due to meeting the definition of custody as defined by subparagraph 50.39(3)*"a"*(3) and that is in compliance with the applicable safekeeping requirements of rule 191—50.39(502) is not required to comply with the net worth requirements of this rule;

d. An investment adviser having custody solely by meeting the definition of custody as defined by subparagraph 50.39(3)*"a"*(4) and that is in compliance with the safekeeping requirements of rule 191—50.39(502) is not required to comply with the net worth requirements of this rule; and

e. An investment adviser having custody solely due to serving as a trustee and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"f"* and the record-keeping requirements of subrule 50.42(4) is not required to comply with the net worth requirements of this rule.

50.40(2) An investment adviser registered or required to be registered pursuant to the Act that has discretionary authority over client funds or securities but does not have minimum net worth requirements due to the custody exceptions of subrule 50.40(1) shall maintain a minimum net worth of $10,000 at all times.

50.40(3) An investment adviser registered or required to be registered pursuant to the Act that accepts payment of more than $500 from a client six or more months in advance of providing services shall maintain a positive net worth at all times.

50.40(4) Unless otherwise exempted, an investment adviser registered or required to be registered pursuant to the Act shall notify the administrator if the investment adviser's net worth is less than the minimum required. Notice must be filed in a report to the administrator no later than the close of business on the next business day following the decrease in net worth. Additionally, an investment adviser shall file by the close of business on the next business day a report with the administrator of the investment adviser's financial condition including, at a minimum, the following:

a. A trial balance of all ledger accounts;

b. A list of all client funds or securities which are not segregated;

c. A computation of the aggregate amount of client ledger debit balances; and

d. The total number of client accounts managed by the investment adviser.

50.40(5) The administrator may require the submission of a current appraisal for the purpose of establishing the worth of any asset.

50.40(6) An investment adviser that has its principal place of business in a state other than this state is not required to maintain the minimum capital required by this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding minimum capital requirements.

50.40(7) For purposes of this rule:

a. "Net worth" means an excess of assets over liabilities calculated in accordance with generally accepted accounting principles. The calculation of assets shall not include the following: prepaid expenses (except those prepaid expenses classified as assets under generally accepted accounting principles); deferred charges, goodwill, franchise rights, organizational expenses, patents, copyrights, marketing rights, unamortized debt discount and expense, and all other assets of intangible nature; home(s), home furnishings, automobile(s), or any other personal items not readily marketable; advances or loans to stockholders or officers; and advances or loans to partners.

b. "Custody" means the same as defined in paragraph 50.39(3)*"a."*

c. An investment adviser shall not be deemed to be exercising discretion when the investment adviser places trade orders with a broker-dealer pursuant to a third-party trading agreement if:

(1) The investment adviser has executed a separate investment adviser contract exclusively with the investment adviser's client which acknowledges that a third-party trading agreement will be executed to allow the investment adviser to effect securities transactions for the client in the client's broker-dealer account;

(2) The investment adviser contract specifically states that the client does not grant discretionary authority to the investment adviser and the investment adviser in fact does not exercise discretion with respect to the account; and

(3) A third-party trading agreement is executed between the client and a broker-dealer which specifically limits the investment adviser's authority in the client's broker-dealer account to the placement of trade orders and deduction of investment adviser fees.

This rule is intended to implement Iowa Code section 502.411(1).

191—50.41(502) Bonding requirements for investment advisers.

50.41(1) Every investment adviser registered or required to be registered under the Act having custody of or discretionary authority over client funds or securities shall be bonded in an amount determined by the administrator based upon the number of clients and the total assets under management of the investment adviser except:

a. An investment adviser that has custody solely due to direct fee deduction and that is also in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"d"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with bonding requirements of this rule;

b. An investment adviser that has custody of or discretionary authority over client funds or securities that does not meet the minimum net worth standard provisions of subrules 50.40(1) and 50.40(2) must be bonded in the amount of the net worth deficiency rounded up to the nearest $5,000;

c. An investment adviser having custody solely due to advising pooled investment vehicles and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"e"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the bonding requirements of this rule;

d. An investment adviser having custody solely due to meeting the definition of "custody" as defined by subparagraph 50.39(3)*"a"*(3) and that is in compliance with the applicable safekeeping

requirements of rule 191—50.39(502) is not required to comply with the bonding requirements of this rule;

e. An investment adviser having custody solely by meeting the definition of "custody" as defined by subparagraph 50.39(3)*"a"*(4) and that is in compliance with the safekeeping requirements of rule 191—50.39(502) is not required to comply with the bonding requirements of this rule;

f. An investment adviser having custody solely due to serving as a trustee and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"f"* and the record-keeping requirements of subrule 50.42(4) is not required to comply with the bonding requirements of this rule.

50.41(2) A bond required by this rule shall be issued by a company qualified to do business in this state in the form determined by the administrator and shall be subject to the claims of clients of the investment adviser regardless of the client's state of residence.

50.41(3) An investment adviser that has a principal place of business in a state other than Iowa is exempt from this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding bonding requirements.

50.41(4) For purposes of this rule, "custody" means the same as defined in paragraph 50.39(3)*"a."*

This rule is intended to implement Iowa Code section 502.411(5).

191—50.42(502) Record-keeping requirements for investment advisers.

50.42(1) An investment adviser registered or required to be registered pursuant to the Act shall make and keep true, accurate and current the following books, ledgers and records:

a. A journal or journals, including cash receipts and disbursements records, and any other records of original entry forming the basis of any ledger entries.

b. General and auxiliary ledgers (or other comparable records) reflecting asset, liability, reserve, capital, income, and expense accounts.

c. A memorandum of each order given by the investment adviser for the purchase or sale of any security, of any instruction received by the investment adviser from the client concerning the purchase, sale, receipt or delivery of a particular security, and of any modification or cancellation of any such order or instruction. The memorandum shall describe the terms and conditions of the order, instruction, modification or cancellation; identify the person connected with the investment adviser who recommended the transaction to the client and the person who placed the order; indicate whether discretionary power was exercised; and indicate the account for which entered, the date of entry, and, where applicable, the bank or broker-dealer by or through whom executed.

d. All checkbooks, bank statements, canceled checks and cash reconciliations of the investment adviser.

e. All invoices, bills, or statements of expenses or debts, or copies of those documents, relating to the investment adviser's business as an investment adviser regardless of whether the expense or debt is paid or unpaid.

f. All trial balances, financial statements prepared in accordance with generally accepted accounting principles, and internal audit working papers relating to the investment adviser's business as an investment adviser. For the purposes of this paragraph, "financial statements" means a balance sheet prepared in accordance with generally accepted accounting principles, an income statement, a cash flow statement, and a net worth computation, if applicable, as required by subrule 50.40(7).

g. Originals of all written communications received by and copies of all written communications sent by the investment adviser relating to:

(1) Any recommendation made or proposed to be made and any advice given or proposed to be given;

(2) Any receipt, disbursement, or delivery of funds or securities; or

(3) The placing or execution of any order to purchase or sell any security, except:

1. The investment adviser shall not be required to keep any unsolicited market letters and other similar communications of general public distribution not prepared by or for the investment adviser; and

2. The investment adviser is not required to keep a record of the names and addresses of persons to whom a notice, circular, or other advertisement offering any report, analysis, publication or other investment advisory service is sent if sent to more than ten persons; however, if the notice, circular, or other advertisement is distributed to persons named on any list, the investment adviser must retain with the copy of the notice, circular, or advertisement a memorandum describing the list and its source.

h. A list or other record of all accounts identifying the accounts in which the investment adviser is vested with any discretionary power with respect to the funds, securities or transactions of any client.

i. Copies of all powers of attorney and other documents granting discretionary authority by any client to the investment adviser.

j. Copies of each agreement entered into by the investment adviser with any client, and all other written agreements otherwise relating to the investment adviser's business as an investment adviser.

k. A file containing copies of each notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons not affiliated with the investment adviser and, if the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including one in electronic media format recommends the purchase or sale of a specific security and does not state the reasons for the recommendation, a memorandum indicating the investment adviser's reasons for the recommendation.

l. A record of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has or by reason of any transaction acquires a direct or indirect beneficial ownership, except the following: transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; and transactions in securities which are direct obligations of the United States.

(1) The required record shall state, at a minimum, the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale or other acquisition or disposition), the price at which the transaction was effected, and the name of the bank or broker-dealer with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction must be recorded no later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be in violation of this paragraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required by this paragraph to be recorded.

(2) For purposes of this paragraph, the following definitions shall apply:

"Advisory representative" means any partner, officer or director of the investment adviser; any employee who participates in any way in the determination of which recommendations shall be made; any employee who, in connection with the employee's duties, obtains any information concerning which securities are being recommended prior to the effective dissemination of the recommendations; and any of the following persons who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations:

1. Any person in a control relationship to the investment adviser;
2. Any affiliated person of a controlling person; and
3. Any affiliated person of an affiliated person.

"Control" means the power to exercise a controlling influence over the management or policies of a company, unless such power results solely from an official position with such company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25 percent of the voting securities of a company shall be presumed to control such company.

m. Notwithstanding the provisions of paragraph *"l,"* when the investment adviser is primarily engaged in a business or businesses other than advising investment advisory clients, a record must be maintained of every transaction in a security in which the investment adviser or any advisory

representative of the investment adviser has, or by reason of any transaction acquires, any direct or indirect beneficial ownership, except:

(1) Transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; or

(2) Transactions in securities which are direct obligations of the United States.

The record shall state the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale, or other acquisition or disposition), the price at which it was effected, and the name of the broker-dealer or bank with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction shall be recorded not later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be deemed to have violated the provisions of this subparagraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required to be recorded. The terms "advisory representative" and "control" shall mean the same as defined in paragraph *"l."*

n. A copy of each written statement and each amendment or revision, given or sent to any client or prospective client of the investment adviser in accordance with rule 191—50.36(502), and a record of the dates on which each written statement, amendment and revision was given or offered to be given to any client or any prospective client who subsequently becomes a client.

o. For each client that was obtained by the investment adviser by means of a solicitor to whom a cash fee was paid by the investment adviser:

(1) A copy of any written agreement relating to the payment of a cash fee to which the investment adviser is a party;

(2) A signed and dated acknowledgment of receipt from the client evidencing the client's receipt of the investment adviser's disclosure statement and a written disclosure statement of the solicitor; and

(3) A copy of the solicitor's written disclosure statement.

The written agreement, acknowledgment and solicitor disclosure statement will be deemed to be in compliance if such documents comply with Rule 275.206(4)-3 of the Investment Advisers Act of 1940.

p. All accounts, books, internal working papers, and any other records or documents that are necessary to form the basis for or demonstrate the calculation of the performance or rate of return of all managed accounts or securities recommendations provided in any notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication, including electronic media, that is directly or indirectly circulated or distributed by the investment adviser to two or more persons (other than persons connected with the investment adviser). However, with respect to the performance of managed accounts only, the retention of all account statements reflecting all debits, credits, and other transactions in a client's account for the period of the statement, and the retention of all worksheets necessary to demonstrate the calculation of the performance or rate of return of the managed account shall satisfy the requirements of this paragraph.

q. A file containing copies of all written communications received or sent regarding any litigation or customer or client complaints involving the investment adviser or any investment adviser representative or employee.

r. The basis, in writing, for any recommendation or investment advice provided to an investment advisory client.

s. Copies of all written procedures regarding the supervision of the employees and investment adviser representatives that are reasonably designed to achieve compliance with securities laws and regulations.

t. A file containing a copy of each document (other than any notices of general dissemination) that was filed with or received from any state or federal agency or self-regulatory organization pertaining to the investment adviser or any investment adviser representative, as defined by paragraph 50.42(1)*"l,"* including but not limited to all applications, amendments, renewal filings, and correspondence.

u. Original copies signed by the lawful signatory of the investment adviser and the investment adviser representative of each initial Form U-4 and each U-4 Amendment to Disclosure Reporting Pages (DRPs).

v. For each transaction in which the investment adviser inadvertently held or obtained the client's securities or funds and returned them to the client within three business days or forwarded a third-party check within 24 hours, a ledger or list of all funds or securities held or obtained with the following information:

(1) Issuer;

(2) Type of security and series;

(3) Date of issue;

(4) For debt instruments, the denomination, interest rate and maturity date;

(5) Certificate number, including alphabetical prefix or suffix;

(6) Name in which registered;

(7) Date submitted to the investment adviser;

(8) Date sent to client or sender;

(9) Form of delivery to client or sender, or copy of the form of delivery to client or sender; and

(10) Mail confirmation number, if applicable, or confirmation by client or sender of the return of the security or fund.

w. For each security exempted from the custody rules by paragraph 50.39(2)*"b"*:

(1) A record showing the issuer's or current transfer agent's name, address, telephone number, and other applicable contact information pertaining to the party responsible for recording the client's interests in the securities; and

(2) A copy of any legend, shareholder agreement, or other agreement providing that the securities are transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

50.42(2) In addition to the retention requirements of subrule 50.42(1), an investment adviser having custody of client funds or securities, as defined by paragraph 50.39(3)*"a,"* shall retain the following records:

a. Copies of all documents executed by each client, including but not limited to a limited power of attorney, pursuant to which the investment adviser is authorized or permitted to withdraw a client's funds or securities;

b. A journal or other record for all accounts reflecting all purchases, sales, receipts, and deliveries of securities, including but not limited to certificate numbers, and all other debits and credits to the accounts;

c. A separate ledger account for each client showing all purchases, sales, receipts and deliveries of securities, the date and price of each purchase or sale, and all debits and credits;

d. Copies of confirmations of all transactions effected by or for the account of any client;

e. A record for each security in which any client has a position showing, at a minimum, the name of each client having an interest in the security, the amount of interest of each client in the security, and the location of each security;

f. A copy of each client's quarterly account statements as generated and delivered by the qualified custodian. Additionally, if the investment adviser generates a statement that is delivered to the client, the investment adviser shall retain copies of those statements along with information indicating the dates on which the statements were provided to the client;

g. If applicable, a copy of the special examination report, financial statements, and letter verifying the completion of and describing the nature and extent of an examination by an independent certified public accountant and documentation describing the nature and extent of the examination and a record regarding any findings of any material discrepancies found during the examination; and

h. If applicable, evidence of the client's designation of an independent representative.

50.42(3) An investment adviser deemed, pursuant to paragraph 50.39(2)*"c,"* to have custody of client securities or funds because the investment adviser advises a pooled investment vehicle shall, in addition to any other applicable record retention requirements, keep the following records:

a. True, accurate, and current account statements;

b. If utilizing the exception provided by paragraph 50.39(2)*"c,"* the date(s) of the audit, a copy of the audited financial statements, and evidence of the mailing of the audited financial statements to all limited partners, members, or other beneficial owners within 120 days of the end of the fiscal year;

c. If subject to paragraph 50.39(1)*"e,"* a copy of the written agreement with the independent party reviewing all fees and expenses and describing the responsibilities of the independent third party, and copies of all invoices and receipts showing approval by the independent third party for payment through the qualified custodian.

50.42(4) An investment adviser deemed, pursuant to paragraph 50.39(2)*"e,"* to have custody because the investment adviser is acting as the trustee for a beneficial trust shall, in addition to any other applicable record retention requirements, retain the following records until the account is closed or the investment adviser is no longer acting as trustee:

a. A copy of the written statement provided to each beneficial owner of the account required pursuant to paragraph 50.39(2)*"e"*; and

b. A copy of the signed and dated statement from each beneficial owner acknowledging the receipt of the written statement pursuant to paragraph 50.39(2)*"e."*

50.42(5) Each investment adviser subject to subrule 50.42(1) that renders investment supervisory or management services to any client shall, with respect to the portfolio being supervised or managed and to the extent that the information is reasonably available to or obtainable by the investment adviser, retain the following records:

a. For each client, detailed information regarding the securities purchased and sold including, but not limited to, the date of the purchase or sale, the total dollar amount of the purchase or sale, and the price at which the security was purchased or sold.

b. For each security in which any client has a current position, the name of each client and current amount or interest of the client.

50.42(6) Records required to be retained pursuant to rule 191—50.42(502) shall be kept as follows:

a. Except as provided in paragraphs 50.42(6)*"b"* to *"e,"* all records shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on record, with no less than the first two years being kept in the principal office of the investment adviser.

b. Partnership articles and any amendments, articles of incorporation, charters, minute books, and stock certificate books of the investment adviser and of any predecessor shall be maintained in the principal office of the investment adviser and preserved until at least three years after termination of the enterprise.

c. Books and records required to be retained pursuant to paragraphs 50.42(1)*"k"* and 50.42(1)*"p"* shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the investment adviser last published or otherwise disseminated, directly or indirectly, the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including by electronic media, with no less than the first two years being kept in the principal office of the investment adviser.

d. Books and records required to be retained pursuant to paragraphs 50.42(1)*"q"* to *"v"* shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record, with no less than the first two years being kept in the principal office of the investment adviser, or the time period during which the investment adviser is registered or required to be registered in this state, whichever is less.

e. An investment adviser that has rendered or renders investment advisory services shall maintain the following records at the investment adviser's business location at all times during the applicable retention period:

(1) All records required to be preserved pursuant to paragraphs 50.42(1)*"c," "g"* to *"j," "n," "o,"* and *"q"* to *"s"* and subrules 50.42(2) to 50.42(5); and

(2) All records required pursuant to paragraphs 50.42(1)*"k"* to *"p"* identifying the name of the investment adviser representative providing investment advice from that business location, or identifying

the physical address, mailing address, electronic mailing address, or telephone number of the business location. The records will be maintained for the period described in paragraph 50.42(6)*"a."*

50.42(7) An investment adviser subject to subrule 50.42(1) that ceases to conduct or discontinues business as an investment adviser shall arrange for and be responsible for the retention of the records required to be retained pursuant to this rule for the applicable retention period. The investment adviser shall notify the administrator in writing prior to ceasing to conduct or discontinuing business as an investment adviser of the exact address where the books and records will be maintained during the retention period.

50.42(8) An investment adviser required to retain records pursuant to this rule may maintain the records in such manner that the identity of any client to whom the investment adviser renders investment supervisory services is indicated by numerical code, alphabetical code, or similar designation.

50.42(9) Record maintenance.

a. Pursuant to subrule 50.42(5), the records required to be maintained and preserved may be immediately produced or reproduced, and maintained and preserved for the required time, by an investment adviser in:

(1) Paper or hard-copy form, as those records are kept in their original form; or

(2) Micrographic media, including microfilm, microfiche, or any similar medium; or

(3) Electronic storage media, including any digital storage medium or system, that meet the terms of this subrule.

b. The investment adviser must:

(1) Arrange and index the records in a way that permits easy location, access, and retrieval of any particular record;

(2) Provide promptly any of the following that the administrator may request:

1. A legible, true, and complete copy of the record in the medium and format in which it is stored;
2. A legible, true, and complete printout of the record; and
3. Means to access, view, and print the records; and

(3) Separately store, for the time required for preservation of the original record, a duplicate copy of the record in any medium allowed by this subrule.

c. In the case of records created or maintained in electronic storage media, the investment adviser must establish and maintain procedures:

(1) To maintain and preserve the records, so as to reasonably safeguard them from loss, alteration, or destruction;

(2) To limit access to the records to properly authorized personnel and the administrator; and

(3) To reasonably ensure that any reproduction of a nonelectronic original record in electronic storage media is complete, true, and legible when retrieved.

50.42(10) Compliance with any substantially similar record-keeping requirements of Rules 17a-3 [17 CFR 240.17a-3] and 17a-4 [17 CFR 240.17a-4] of the Securities Exchange Act of 1934 shall be deemed to be in compliance with this rule.

50.42(11) Every investment adviser that is registered or required to be registered in this state and that has its principal place of business in a state other than this state shall be exempt from the requirements of this rule, provided the investment adviser is properly registered in that state and is in compliance with that state's record-keeping requirements.

50.42(12) For purposes of this rule:

"Advisory representative" means any partner, officer or director of the investment adviser; any employee who participates in any way in the determination of which recommendations shall be made; any employee who, in connection with the employee's duties, obtains any information concerning which securities are being recommended prior to the effective dissemination of the recommendations; and any of the following persons who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations:

1. Any person in a relationship of control with the investment adviser;
2. Any person affiliated with a controlling person; and
3. Any person affiliated with an affiliated person.

"Control" means the power to exercise a controlling influence over the management or policies of a company, unless that power results solely from an official position with the company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25 percent of the voting securities of a company shall be presumed to control the company.

An investment adviser shall not be deemed to be exercising a discretionary power as to the price at which or the time when a transaction is effected or is to be effected if, before the order is given by the investment adviser, the client has directed or approved the purchase or sale of a definite amount of the particular security.

"Investment adviser primarily engaged in a business or businesses other than advising investment advisory clients" means an investment adviser that for each of the most recent three fiscal years or for the period of time since organization, whichever is less, derives on an unconsolidated basis more than 50 percent of total sales and revenues and income (or loss) before income taxes and extraordinary items from business activities other than advising investment advisory clients.

"Investment supervisory services" means continuous advice regarding investment of funds provided to each client on the basis of the individual needs of the client.

"Solicitor" means any person or entity that for compensation acts as an agent of an investment adviser in referring potential clients.

This rule is intended to implement Iowa Code section 502.411(3).

191—50.43(502) Financial reporting requirements for investment advisers.

50.43(1) Every registered investment adviser that has custody of client funds or securities or requires payment of advisory fees six months or more in advance and in excess of $500 per client shall file with the administrator an audited balance sheet as of the end of the investment adviser's fiscal year except:

a. An investment adviser that has custody solely due to direct fee deduction and that is also in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"d"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the financial reporting requirements of this rule;

b. An investment adviser that has custody solely due to advising pooled investment vehicles and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"e"* or 50.39(2)*"c"* and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the financial reporting requirements of this rule; and

c. An investment adviser that has custody solely due to serving as a trustee and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)*"f"* and the record-keeping requirements of subrule 50.42(4) is not required to comply with the financial reporting requirements of this rule.

50.43(2) Every registered investment adviser that has discretionary authority over, but not custody of, client funds or securities shall file with the administrator a balance sheet, which need not be audited, but which must be prepared in accordance with generally accepted accounting principles and represented by the investment adviser or the person who prepared the statement as true and accurate, as of the end of the investment adviser's fiscal year.

50.43(3) Each balance sheet filed pursuant to this rule must be:

a. Examined in accordance with generally accepted auditing standards and prepared in conformity with generally accepted accounting principles;

b. Audited by an independent certified public accountant; and

c. Accompanied by an opinion of the accountant as to the report of financial position, and by a note stating the principles used to prepare the audit, the basis of included securities, and any other explanations required for clarity.

50.43(4) The financial statements required by this rule shall be filed with the administrator within 90 days following the end of the investment adviser's fiscal year.

50.43(5) Every investment adviser that has its principal place of business in a state other than this state shall file only such reports as required by the state in which the investment adviser maintains its

principal place of business, provided the investment adviser is licensed in such state and is in compliance with such state's financial reporting requirements.

This rule is intended to implement Iowa Code section 502.411(2).

191—50.44(502) Solely incidental services by certain professionals.

50.44(1) *General approach.*

a. Certain professionals may rely on an exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15)*"b"* for lawyers, accountants, engineers or teachers whose performance of investment advice is solely incidental to the practice of the person's profession. Whether the exclusion from the definition of "investment adviser" is available to a lawyer, accountant, engineer or teacher providing investment advisory services within the meaning of Iowa Code section 502.102(15)*"b"* depends upon the relevant facts and circumstances.

b. In general, the administrator will determine whether the investment advisory services provided and the fees charged are solely incidental to the total services provided to the individual client by comparing whether the aggregate of such fees and services is solely incidental to the aggregate of services provided to all clients. In addition, the administrator will take other relevant factors into consideration in determining the applicability of the exclusion including, but not limited to, whether the firm establishes a separate subsidiary, division, or other business entity to perform advisory services or maintains an investment adviser registration with the U.S. Securities and Exchange Commission under the Investment Advisers Act of 1940. In this context, the administrator would refer to U.S. Securities and Exchange Commission Release IA-1092 relating to the analogous exclusion in the Investment Advisers Act of 1940 which states that ". . . the exclusion . . . is not available . . . to a lawyer or accountant who holds himself out to the public as providing financial planning, pension consulting, or other financial advisory services. In such a case it would appear that the performance of investment advisory services by the person would not be solely incidental to his practice as a lawyer or accountant."

50.44(2) *General versus specific advice.* A lawyer, accountant, engineer or teacher, whether or not holding oneself out to the public as providing financial planning or other financial advisory services, who does not render advice with respect to investing in specific securities, types of securities, or categories of securities need not register as an investment adviser. Registration is not required when the securities advice provided to clients in this state is limited to a general recommendation that the client should be more aggressive or more conservative in securities investments, a general recommendation as to the percentage of the client's assets that should be in securities, or a general recommendation that the client pursue an income-producing or growth-oriented investment strategy, provided the recommendation does not identify specific securities, types of securities, or categories of securities. For the purpose of this subrule, the phrase "types of securities" means classes of securities in which the issuer is not specifically identified, such as common stock, preferred stock, options, warrants, bonds, and mutual funds, and the phrase "categories of securities" means general areas of securities investments where neither the issuer nor the types of securities are identified such as cyclical securities, automotive industry securities, international securities, and NYSE securities. Asset allocation recommendations, however, generally do include advice on types of securities.

EXAMPLE: An accountant provides clients accounting and financial planning services. No advice with respect to specific securities, types of securities, or categories of securities is provided. The accountant need not register as an investment adviser.

50.44(3) *Professional does not hold self out as a financial planner.* When the securities advice is provided by a lawyer, accountant, engineer, or teacher who does not hold oneself out to the public as providing financial planning or other financial advisory services, the availability of the exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15)*"b"* for securities advice rendered solely incidental to the profession will depend on those factors set forth in paragraph 50.44(1)*"b."*

EXAMPLE A: An accountant who does not hold oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The services involve advice with respect to specific securities, types of securities, or categories

of securities. Whether the accountant is excluded from the definition of investment adviser depends on those factors set forth in paragraph 50.44(1)*"b,"* including a comparison of the extent of the securities advisory services provided to any client as contrasted with the accounting services provided to that client. The comparison is measured by the compensation paid for each service.

EXAMPLE B: An accountant provides a client financial planning services only. The financial planning services involve advice with respect to specific securities, types of securities, or categories of securities. The accountant is not excluded from the definition of investment adviser and therefore must register as an investment adviser.

50.44(4) *Professional holds self out as a financial planner.*

a. If the investment advice provided by a lawyer, accountant, engineer, or teacher who holds oneself out to the public as providing financial planning or other financial advisory services is part of the financial plan being provided to a financial planning client, the professional cannot rely on the exclusion from the definition of "investment adviser" contained in Iowa Code section 502.102(15)*"b"* for investment advice rendered incidentally to the practice of the profession.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The financial planning services involve advice with respect to specific securities, types of securities, or categories of securities. The accountant is not excluded from the definition of investment adviser no matter how insignificantly the securities advice compares to the other financial planning advice or accounting services rendered.

b. When a lawyer, accountant, engineer, or teacher holding oneself out to the public as providing financial planning or other financial advisory services does not provide advice on specific securities, types of securities, or categories of securities as part of financial planning services but provides such advice in connection with the practice of the profession, in most instances the exclusion from the definition of investment adviser would be unavailable because the professional is holding oneself out as a financial planner or financial adviser. If, however, securities advice is not part of financial planning services and is both limited and isolated, the exclusion may still be available.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides clients both accounting and financial planning services. No securities advice is rendered as part of the financial planning services. Clients, on a few occasions, request the accountant's advice on investing in certain limited partnerships. The fees charged to such a client for the advice total only a small percentage of the fees charged to that client for accounting services provided. The accountant is excluded from the definition of investment adviser. The example presented is intentionally narrow in order to illustrate that once the accountant holds oneself out as a financial planner or financial adviser, even if the only securities advice provided for compensation is not part of the financial planning or advisory activities, only limited and isolated securities advice may be provided without registration as an investment adviser.

This rule is intended to implement Iowa Code section 502.102(15)*"b."*

191—50.45 to **50.49** Reserved.

DIVISION IV
RULES COVERING ALL REGISTERED PERSONS

191—50.50(502) Internet advertising by broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers.

50.50(1) Broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers who use the Internet, the World Wide Web, or similar proprietary or common carrier electronic systems (collectively described as the "Internet") to disseminate information regarding products and services through communications directed generally to anyone having access to the Internet and transmitted through posting on bulletin boards, displays on home pages or similar methods (hereinafter "Internet communications") will not be considered to

be transacting business in Iowa pursuant to Iowa Code section 502.401, 502.402, 502.403, 502.404, or 502.405 based solely on that communication, if:

a. The Internet communication contains a legend clearly stating that:

(1) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser may only transact business in a state if first registered pursuant to or excluded or exempt from the state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement; and

(2) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser will not effect or attempt to effect transactions in securities or render personalized investment advice for compensation absent compliance with applicable state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement or applicable exemption or exclusion;

b. The Internet communication contains a mechanism, including but not limited to technical firewalls or other policies and procedures, to ensure that, prior to effecting or attempting to effect transactions with customers in Iowa or prior to direct communication with prospective customers or clients in Iowa, the broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative is first registered in Iowa or, in the case of a federal covered investment adviser, has made a notice filing, or qualifies for an exemption or exclusion from registration requirements;

c. The Internet communication is limited to general information regarding products and services, and the broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser does not effect or attempt to effect transactions in securities in Iowa or provide personalized investment advice for compensation; and

d. In the case of a broker-dealer agent or investment adviser representative:

(1) The agent's broker-dealer, investment adviser, or federal covered investment adviser affiliation is prominently disclosed within the Internet communication;

(2) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is affiliated reviews and approves the content of any Internet communication by the broker-dealer agent or investment adviser representative;

(3) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is associated first authorizes the dissemination of information on the particular products and services through the Internet communication; and

(4) The broker-dealer agent or investment adviser representative acts within the scope of the authority granted by the broker-dealer, investment adviser, or federal covered investment adviser in the dissemination of information through the Internet communication.

50.50(2) Nothing in this rule shall excuse broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, and federal covered investment adviser compliance with applicable securities registration, notice filing, antifraud or related provisions.

50.50(3) Nothing in this rule shall be construed to affect the activities of any broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser engaged in business in Iowa that is not subject to the jurisdiction of the administrator as a result of NSMIA.

This rule is intended to implement Iowa Code sections 502.401 to 502.405.

191—50.51(502) Consent to service.

50.51(1) Every consent appointing the administrator or successor to be an attorney to receive service of any lawful process as required by Iowa Code section 502.611 shall be properly notarized and shall contain, at a minimum, the following information:

a. Name of the applicant;

b. Address of the applicant;

c. A statement that the consent is irrevocable;

d. A statement that the consent is valid as to any noncriminal suit, action or proceeding against the applicant or the successor, executor or administrator of the applicant which arises out of the Act; and

e. A statement that the applicant stipulates and agrees that service upon the administrator shall have the same validity as if served personally upon the applicant.

50.51(2) A form of consent to service of process provided by the administrator, a Form U-2, or a consent to service of process contained in any other form authorized or required to be filed by these rules shall satisfy subrule 50.51(1).

50.51(3) A broker-dealer, investment adviser, agent, investment adviser representative, federal covered investment adviser, or issuer may incorporate by reference any consent to service of process required to be filed pursuant to Iowa Code sections 502.302(1)*"a,"* 502.302(3), 502.303(2), 502.304(2), 502.406(1) and 502.611, or the administrative rules implementing these sections.

This rule is intended to implement Iowa Code section 502.611.

191—50.52(252J) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay child support.

50.52(1) Upon receipt of a certificate of noncompliance from the CSRU for default on debts owed to or collected by the CSRU, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration will be denied or any current registration will be suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

50.52(2) The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant that:

a. The administrator intends to deny an application or to suspend or revoke a registration due to receipt of a certificate of noncompliance from the CSRU;

b. The applicant or registrant must contact the CSRU to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

c. Unless the CSRU furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

d. The applicant or registrant does not have a right to a hearing before the administrator, but may, pursuant to Iowa Code section 252J.9, request a court hearing within 30 days of provision of notice by the administrator; and

e. The filing of an application for hearing with the district court will stay the proceedings of the division.

50.52(3) The filing of an application for hearing with the district court under Iowa Code section 252J.9 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

50.52(4) If the administrator does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice that an application for district court hearing has been filed, the administrator shall deny, suspend or revoke the application or registration 30 days after the notice prescribed in subrule 50.52(2) is issued.

50.52(5) Upon receiving a withdrawal of the certificate of noncompliance from the CSRU, the administrator shall immediately halt action to deny an application or suspend or revoke a registration. The applicant or registrant shall be notified that action has been halted. If the application has already been denied or if a registration has already been suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

50.52(6) All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code chapter 252J.

50.52(7) Notwithstanding any statutory confidentiality provision, the administrator may share information with the CSRU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code chapter 252J.

This rule is intended to implement Iowa Code chapter 252J.

191—50.53(261) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay debts owed to or collected by the college student aid commission.

50.53(1) Upon receipt of a certificate of noncompliance from the college student aid commission for defaults on debts owed to or collected by the commission, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration or any current registration will be denied, suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

50.53(2) The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant or registrant that:

a. The administrator intends to deny an application or suspend or revoke a registration due to receipt of a certificate of noncompliance from the college student aid commission;

b. The applicant or registrant must contact the college student aid commission to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

c. Unless the college student aid commission furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

d. The applicant or registrant does not have a right to a hearing before the administrator but may, pursuant to Iowa Code section 261.126, request a district court hearing within 30 days of provision of notice by the administrator; and

e. The filing of an application for hearing with the district court will stay the proceedings of the division.

50.53(3) The filing of an application for hearing with the district court under Iowa Code section 261.127 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

50.53(4) If the administrator does not receive a withdrawal of the certificate of noncompliance from the college student aid commission or a notice that an application for district court hearing has been filed, the administrator shall deny the application or suspend or revoke the registration 30 days after the notice prescribed in subrule 50.53(2) is issued.

50.53(5) If the administrator receives a withdrawal of the certificate of noncompliance from the college student aid commission, the administrator shall immediately halt action to deny, suspend or revoke an application or registration. The applicant or registrant shall be notified that action has been halted. If the application or registration has already been denied, suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

50.53(6) All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code section 261.126.

50.53(7) Notwithstanding any statutory confidentiality provision, the administrator may share information with the CSRU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code section 261.126.

This rule is intended to implement Iowa Code section 261.126.

191—50.54(502) Use of senior-specific certifications and professional designations.

50.54(1) The use of a senior-specific certification or designation by any person in connection with the offer, sale, or purchase of securities or the provision of advice as to the value of or the advisability

of investing in, purchasing, or selling securities, either directly or indirectly or through publications or writings, or by issuing or promulgating analyses or reports relating to securities, that indicate or imply that the user has special certification or training in advising or servicing senior citizens or retirees in such a way as to mislead any person shall be a dishonest and unethical practice in the securities, commodities, investment, franchise, banking, finance, or insurance business within the meaning of Iowa Code section 502.412(4)*"m."* The prohibited use of such certifications or professional designation includes, but is not limited to, the following:

a. Use of a certification or professional designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;

b. Use of a nonexistent or self-conferred certification or professional designation;

c. Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; and

d. Use of a certification or professional designation that was obtained from a designating or certifying organization that:

(1) Is primarily engaged in the business of instruction in sales or marketing;

(2) Does not have reasonable standards or procedures for ensuring the competency of its designees or certificants;

(3) Does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or

(4) Does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

50.54(2) There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of 50.54(1)*"d"* when the organization has been accredited by:

a. The American National Standards Institute;

b. The National Commission for Certifying Agencies; or

c. An organization that is on the United States Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes" and the designation or credential issued therefrom does not primarily apply to sales or marketing.

50.54(3) In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, the administrator shall consider the following factors:

a. Use of one or more words such as "senior," "retirement," "elder," or similar words combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or similar words in the name of the certification or professional designation; and

b. The manner in which those words are combined.

50.54(4) For purposes of this rule, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency, when that job title:

a. Indicates seniority or standing within the organization; or

b. Specifies an individual's area of specialization within the organization.

For purposes of this subrule, financial services regulatory agency includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

50.54(5) Nothing in this rule shall limit the administrator's authority to enforce existing provisions of law.

This rule is intended to implement Iowa Code section 502.605(1).

191—50.55 to **50.59** Reserved.

DIVISION V
REGISTRATION OF SECURITIES

191—50.60(502) Notice filings for investment company securities offerings.

50.60(1) Except as provided in subrule 50.60(5), no investment company that is registered under the Investment Company Act of 1940 or that has a currently filed registration statement under the Securities Act of 1933 is required to file with the administrator, either prior to the initial offer or after the initial offer in Iowa of a security which is a covered security under Section 18(b)(2) of the Securities Act of 1933, a copy of any document which is part of a federal registration statement filed with the SEC or is part of an amendment to such federal registration statement.

50.60(2) Prior to the initial offer of a federal covered security in Iowa, an investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file with the administrator:

a. A notice of filing on Form NF;

b. A filing fee; and

c. A consent to service of process.

50.60(3) A notice of filing may be renewed prior to expiration by filing the following with the administrator:

a. A notice of filing on Form NF; and

b. Payment of the applicable fee under Iowa Code section 502.302(1)*"a."*

50.60(4) Amendments to notice filings are made on Form NF and are effective upon receipt by the administrator. Withdrawal or termination of a notice filing is made by filing Form NF or providing the administrator with notice of the withdrawal or termination in a similar format. An amendment, withdrawal, or termination is effective upon receipt by the administrator of the required notice and all fees required by Iowa Code section 502.302(1)*"a."*

50.60(5) An investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file, upon written request of the administrator and within the time period set forth in the request, a copy of any document identified in the request that is part of the federal registration statement filed with the SEC or part of an amendment to such federal registration statement.

50.60(6) An investment company that makes a notice filing under subrule 50.60(2) and that pays an initial $250 filing fee under Iowa Code section 502.302(1)*"a"* shall pay an additional $1,250 filing fee within 90 days after the notice filing's annual renewal date, or shall file on Form NF an annual or periodic report of the value of the federal covered securities offered or sold in Iowa, together with a filing fee of one-tenth of 1 percent of the amount of securities sold in excess of $250,000.

This rule is intended to implement Iowa Code section 502.302(1).

191—50.61(502) Registration of small corporate offerings.

50.61(1) Form U-7 may be obtained by contacting the Iowa Securities and Regulated Industries Bureau, 340 East Maple Street, Des Moines, Iowa 50319-0066; via E-mail at iowa.sec.@iid.state.ia.us; or from the division Web site at http://www.iid.state.ia.us/division/securities. Form U-7 has been developed under the Small Business Investment Incentive Act of 1980 which prescribes state and federal cooperation in furthering the policies of the Act: diminishing the burden of raising investment capital and minimizing interference with the business of capital formation.

50.61(2) To be eligible to use Form U-7, the issuer shall comply with each of the following requirements:

a. The issuer shall:

(1) Be a corporation or limited liability company organized under the laws of the United States or Canada, or any state, province, or territory or possession thereof, or the District of Columbia and have its principal place of business in one of the foregoing;

(2) Not be subject to the reporting requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934;

(3) Not be an investment company registered or required to be registered under the Investment Company Act of 1940;

(4) Not be engaged in or propose to be engaged in petroleum exploration and production, mining, or other extractive industries;

(5) Not be a development stage company that either has no specific business plan or purpose or has indicated that its business plan is to engage in a merger or acquisition with an unidentified company or companies or other entity or person; and

(6) Not be disqualified under subrule 50.61(3).

b. The offering price for common stock or common ownership interests (hereinafter, collectively referred to as "common stock"), the exercise price for options, warrants, or rights to common stock, or the conversion price for securities convertible into common stock must be greater than or equal to U.S. $1 per share or unit of interest. The issuer must agree with the administrator that the issuer will not split its common stock, or declare a stock dividend for two years after the effective date of the registration if such action has the effect of lowering the price below U.S. $1.

c. Commissions, fees or other remuneration for soliciting any prospective purchaser in connection with the offering in the state are only paid to persons who, if required to be registered or licensed, the issuer believes, and has reason to believe, are appropriately registered or licensed in the state.

d. Financial statements shall be prepared in accordance with either U.S. or Canadian generally accepted accounting principles. If appropriate, a reconciliation note should be provided. If the company has not conducted significant operations, statements of receipts and disbursements shall be included in lieu of statements of income. Interim financial statements may be unaudited. All other financial statements shall be audited by independent certified public accountants, provided, however, that if each of the following four conditions are met, such financial statements in lieu of being audited may be reviewed by independent certified public accountants in accordance with the Accounting and Review Service Standards promulgated by the American Institute of Certified Public Accountants or the Canadian equivalent:

(1) The company shall not have previously sold securities through an offering involving the general solicitation of prospective investors by means of advertising, mass mailings, public meetings, "cold call" telephone solicitation, or any other method directed toward the public;

(2) The company has not been previously required under federal, state, provincial or territorial securities laws to provide audited financial statements in connection with any sale of its securities;

(3) The aggregate amount of all previous sales of securities by the company (exclusive of debt financing with banks and similar commercial lenders) shall not exceed U.S. $1 million; and

(4) If the offering is a Rule 504 offering, the amount of the present offering does not exceed U.S. $1 million.

e. The offering shall be made in compliance with Rule 504 of Regulation D, Regulation A, or Section 3(a)(11) of the Securities Act of 1933.

f. The issuer shall comply with the General Instructions to SCOR in Part I of the NASAA SCOR Issuer's Manual.

50.61(3) Disqualifications.

a. Unless the administrator determines that it is not necessary under the circumstances that the disqualification under this subrule be applied, application for registration referred to in subrule 50.61(2) shall be denied if the issuer, any of its officers, directors, stockholders who own 10 percent or greater of the issuer, promoters, or selling agents, or any officer, director or partner of any selling agent:

(1) Has filed a registration statement which is subject to a currently effective stop order entered pursuant to any state or provincial securities laws within five years prior to the filing of the registration statement;

(2) Has been convicted, within five years prior to the filing of the registration statement, of any felony or misdemeanor in connection with the offer, purchase, or sale of securities, or of any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state or provincial administrative enforcement order or judgment entered by that state's or province's securities administrator within five years prior to the filing of the registration statement;

(4) Is subject to any state or provincial administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found, and the order or judgment was entered within five years prior to the filing of the current application for registration;

(5) Is subject to any state or provincial administrative enforcement order or judgment which prohibits, denies, or revokes the use of any exemption from registration in connection with the offer, purchase or sale of securities;

(6) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction that temporarily, preliminarily, or permanently restrains or enjoins such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of any security, or involving the making of any false filing with the state, entered within five years prior to the filing of the registration statement; or

(7) Has violated the law of a foreign jurisdiction governing or regulating any aspect of the business of securities or banking or, within the past five years, has been the subject of an action of a securities regulator of a foreign jurisdiction denying, revoking or suspending the right to engage in the business of securities as a broker-dealer, agent or investment adviser or is the subject of an action of any securities exchange or self-regulatory organization operating under the authority of the securities regulator of a foreign jurisdiction suspending or expelling such person from membership in such exchange or self-regulatory organization.

b. The prohibitions of subparagraphs (1) to (3) and (5) of paragraph 50.61(3)*"a"* shall not apply if the person subject to the disqualification is duly registered or licensed to conduct securities-related business in the state or province in which the administrative order or judgment was entered against such person, or if the broker-dealer employing such person is registered or licensed in the state and the Form BD filed in the state discloses the order, conviction, judgment or decree relating to such person.

c. No person disqualified shall act in any capacity other than the capacity for which the person is registered or licensed.

d. Disqualification is automatically waived if the jurisdiction which created the basis for disqualification determines upon a showing of good cause that it is not necessary under the circumstances that registration be denied.

This rule is intended to implement Iowa Code section 502.304.

191—50.62(502) Streamlined registration for certain equity securities.

50.62(1) An equity security meeting the conditions of this rule may be registered pursuant to Iowa Code section 502.303 if all of the following conditions are satisfied, unless waived by the administrator, and except as provided by subrule 50.62(2):

a. The issuer must be a corporation organized under the laws of one of the states or possessions of the United States;

b. The offering price for common stock, the exercise price if the securities are options, warrants, or rights for common stock, or the conversion price if the securities are convertible into common stock must be equal to or greater than $5 per share;

c. The issuer of the security has (or will have upon completion of the offering) total assets exceeding $10 million;

d. The security will be offered under a firm underwriting;

e. The security is the subject of a registration statement filed on Form S-1 or Form SB-2 with the SEC; and

f. The registration statement filed with the administrator contains audited financial statements for each of the two most recently concluded fiscal years of its operations, and the audit for the most recent fiscal year does not include an auditor's report expressing substantial doubt about the issuer's ability to continue as a going concern.

50.62(2) Registration pursuant to this rule is not available if:

a. The issuer is a blind pool or other offering for which the specific business or properties cannot now be described; or

b. The issuer, a principal officer or a principal shareholder thereof, or a broker-dealer offering or selling the securities:

(1) Is subject to statutory disqualification, as defined by subparagraphs (A), (B), (C), or (D) of Section 3(a)(39) of the Securities Exchange Act of 1934;

(2) Has been convicted of any felony under federal or state law regarding the offer, purchase, or sale of any security, or any felony under federal or state law involving fraud or deceit in the ten years prior to the date of the offering;

(3) Is currently named in and subject to any order, judgment, or decree of any court of competent jurisdiction acting under federal or state law temporarily or permanently restraining or enjoining the person from engaging in or continuing any conduct or practice in connection with the offer, purchase, or sale of a security;

(4) Has filed a registration statement which is currently the subject of a stop order entered pursuant to any state's securities law within five years prior to the offering;

(5) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to the offering, or is currently subject to any state's administrative enforcement order or judgment in which fraud or deceit was found within five years prior to the offering; or

(6) Is currently subject to any state's administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, sale, or purchase of any security, or involving the making of a false filing with the state within five years of the offering.

50.62(3) The unavailability of streamlined registration pursuant to this rule as a result of the disqualification of a party pursuant to paragraph 50.62(2)*"b"* may be waived by the administrator if the order, conviction, judgment or decree relating to the party's disqualification was disclosed in writing to the administrator and the administrator determines, based upon good cause shown, that the public interest no longer requires the party to be disqualified.

50.62(4) The administrator shall review a filing made pursuant to this rule within ten business days of receipt. Registration shall be effective upon review, or earlier if the administrator permits a shorter time frame, or comments explaining noncompliance will be promptly sent to the applicant.

50.62(5) The administrator shall not deny the effectiveness of a registration made pursuant to this rule based on subrule 50.66(13) or 50.66(15), or based upon the financial condition of the issuer under Iowa Code section 502.306(1)*"h."*

50.62(6) The following securities shall be the subject of a lockup with the managing underwriter for no less than 180 days, or a longer period if requested by the managing underwriter of the offering:

a. A security issued to a promoter within three years immediately preceding the offering or to be issued to a promoter for consideration substantially less than the offering price; or

b. A security issued to a promoter for a consideration other than cash, unless the registrant demonstrates that the value of the noncash consideration received in exchange for the security is substantially equal to the offering price for the security. A copy of the lockup agreement shall be filed with the administrator.

50.62(7) For purposes of this rule, a "promoter" is:

a. A person who, acting alone or in concert with one or more other persons, founds or organizes the business or enterprise of the issuer;

b. An officer or director owning securities of the issuer, or a person who owns, beneficially or of record, 10 percent or more of a class of securities of the issuer if the officer, director, or person acquires any of those securities in a non-arm's-length transaction within the three years prior to the filing of the registration statement pursuant to this rule; or

c. A member of the immediate family of a person described in paragraph *"a"* or *"b"* of subrule 50.62(7) if the family member receives securities of the issuer from that person in a non-arm's-length transaction within the three years prior to the filing of the registration statement pursuant to this rule.

This rule is intended to implement Iowa Code section 502.303.

191—50.63(502) Registration of multijurisdictional offerings.

50.63(1) Pursuant to Iowa Code section 502.303(2), offerings filed on SEC Form F-7, Form F-8, Form F-9 or Form F-10 shall become effective the later of three days after filing, or the effective date with the SEC.

50.63(2) Pursuant to Iowa Code section 502.605(3), financial statements and financial information for offerings filed under subrule 50.63(1) shall comply with instructions provided with SEC Form F-7, Form F-8, Form F-9 or Form F-10.

50.63(3) In a Rights Offering, SEC Form F-7 will be accepted in lieu of any state form required to claim an exemption for any transaction pursuant to an offer to existing securities holders.

50.63(4) After the SEC has declared effective an issuer's Form F-8, Form F-9 or Form F-10 registration statement, a nonissuer transaction in any class of the issuer's securities is exempt from registration, whether or not the transaction is effected through a broker-dealer.

This rule is intended to implement Iowa Code sections 502.303(2) and 502.605(3).

191—50.64(502) Form of financial statements.

50.64(1) Except as otherwise provided by this rule, the balance sheet, statement of cash flows, and statement of income required by Iowa Code section 502.304(2)*"q"* shall be certified by an independent certified public accountant who shall also issue an opinion on the financial statements. The audit and opinion requirements may be waived by the administrator upon written application and for good cause shown.

50.64(2) The balance sheet, statement of cash flows, and statement of income provided for compliance with the four-month requirement of Iowa Code section 502.304(2)*"q"* need not be certified in accordance with subrule 50.64(1) if such certification was submitted for the last fiscal year prior to the application and the date of the financial statements subject to certification is not more than 12 months prior to the registration date.

This rule is intended to implement Iowa Code section 502.304.

191—50.65(502) Reports contingent to registration by qualification. In the administrator's discretion, a registration by qualification statement filed pursuant to Iowa Code section 502.304 may not become effective until one or both of the following are filed:

1. When the value, after its purchase, of certain property does or will constitute a material portion of the assets of the issuer or any other person whose financial condition is significant to the registration, the report of any appraiser or engineer; and
2. When the ownership of any such property is material to the registration, a signed opinion of legal counsel regarding ownership of any property.

This rule is intended to implement Iowa Code section 502.304(2A).

191—50.66(502) NASAA guidelines and statements of policy.

50.66(1) *Overview of national models.* In cooperation with the securities administrators of other states and with a view to effectuating a policy to achieve maximum uniformity of regulations regarding the registration of securities, registration and business practices of securities industry and investment advisory registrants, and enforcement of antifraud laws, and in the interest of streamlining the rules contained in Chapter 50, the administrator incorporates by reference the following guidelines and statements of policy promulgated by NASAA. This rule does not include any later amendments or editions of the incorporated matter.

The official reporter for NASAA statements of policy is the NASAA Reports volume printed by CCH. A copy of the CCH NASAA Reports is available to the public during regular business hours

at the office of the administrator. Upon request, and for a reasonable fee not to exceed the cost of providing the service, the administrator will furnish to any person photostatic or other copies of the following NASAA guidelines and statements of policy. The office of the administrator is located at and requests may be mailed to the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066; via E-mail at iowa.sec@iid.state.ia.us; or from the division Web site at http:// www.iid.state.ia.us/division/securities. NASAA statements of policy may also generally be found at www.nasaa.org.

50.66(2) *Registration of oil and gas programs.* All oil and gas programs filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Oil and Gas Programs, which were initially adopted by the NASAA membership on September 22, 1976, as amended on October 12, 1977; October 31, 1979; April 23, 1983; July 1, 1984; September 3, 1987; September 14, 1989; October 24, 1991; and May 7, 2007; and published in CCH NASAA Reports at paragraph 2621.

50.66(3) *Uniform disclosure guidelines—legend.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Cover Legends as adopted by the NASAA membership on October 2, 2004, and published in CCH NASAA Reports at paragraph 1351.

50.66(4) *Omnibus guidelines.* All registrations of limited or general partnerships, joint ventures, unincorporated associations, or similar organizations, other than a corporation formed and operated for the primary purpose of investment in and the operation of or gain from and interest in the assets to be acquired by such entity for which statements of policy have not been adopted by the NASAA membership, filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Omnibus Guidelines as adopted by the NASAA membership on March 29, 1992, as amended on May 7, 2007; and published in CCH NASAA Reports at paragraph 2321.

50.66(5) *Registration of commodity pool programs.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Commodity Pool Programs as adopted by the NASAA membership on September 21, 1983, effective January 1, 1984, amended August 30, 1990, amended May 2007, and published in CCH NASAA Reports at paragraph 1201.

50.66(6) *Registration of equipment programs.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Equipment Programs as adopted by the NASAA membership on November 20, 1986, effective January 1, 1987, amended April 22, 1988, October 24, 1991, and May 7, 2007, and published in CCH NASAA Reports at paragraph 1601.

50.66(7) *Registration of real estate programs.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Real Estate Programs as adopted by the NASAA membership on September 29, 1993, last revised, May 7, 2007, and published in CCH NASAA Reports at paragraph 3601.

50.66(8) *Registration of mortgage programs.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Mortgage Programs as adopted by the NASAA membership on September 10, 1996, amended May 2007, and published in CCH NASAA Reports, paragraph 701.

50.66(9) *Real estate investment trusts.* The registration of a real estate investment trust may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Real Estate Investment Trusts as revised and adopted by the NASAA membership on September 29, 1993, as revised on May 7, 2007, and published in CCH NASAA Reports at paragraph 3401.

50.66(10) *Corporate securities definitions.* For securities registration purposes, the administrator adopts the various definitions set out in the NASAA Statement of Policy Regarding Corporate Securities Definitions as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 3812.

50.66(11) *Impoundment of proceeds.* When an impoundment of proceeds is necessary, it shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding the Impoundment of Proceeds as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 2151.

50.66(12) *Loans and other material affiliated transactions.* When there have been or will be loans or other material affiliated transactions, the transactions shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Loans and Other Material Affiliated Transactions as amended by the NASAA membership on April 27, 1997, and published in CCH NASAA Reports at paragraph 374.

50.66(13) *Options and warrants.* The issuance of options and warrants may be allowed by the administrator if the issuance is in substantial compliance, as determined by the administrator, with the NASAA Statement of Policy Regarding Options and Warrants as amended by the NASAA membership on November 17, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 2801.

50.66(14) *Preferred stock.* A public offering of preferred stock may be allowed by the administrator if the offering substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Preferred Stock as amended by the NASAA membership on April 27, 1997, and published in CCH NASAA Reports at paragraph 3001.

50.66(15) *Promotional shares.* The registration of a security may include promotional shares if it substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Promotional Shares as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 3201.

50.66(16) *Risk disclosure.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Risk Disclosure as adopted by the NASAA membership on September 8, 2001, and published in CCH NASAA Reports at paragraph 1362.

50.66(17) *Unsound financial condition.* An issuer may be deemed to be in an unsound financial condition if it substantially meets, as determined by the administrator, the conditions provided within the NASAA Statement of Policy Regarding Unsound Financial Condition as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 3821.

50.66(18) *Use of proceeds.* The registration of a security may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Specificity in Use of Proceeds as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and published in CCH NASAA Reports at paragraph 3831.

50.66(19) *Registration of asset-backed securities.* All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Asset-Backed Securities as adopted by the NASAA membership on October 25, 1995, amended May 2007, and published in CCH NASAA Reports at paragraph 501.

This rule is intended to implement Iowa Code sections 502.305(6) and 502.306(1).

191—50.67(502) Amendments to registration by qualification. A registration statement registered by qualification pursuant to Iowa Code section 502.304 is presumed to be reasonably current for purposes of Iowa Code section 502.305(9) if:

1. The issuer notifies the administrator in writing of any change in a material fact contained in the registration statement no later than 7 days after the issuer learns of the change; and

2. The issuer notifies the administrator in writing of the results of an annual audit or semiannual report no later than 14 days after receiving such audit results or semiannual report unless the results constitute a change in material fact subject to the provisions of paragraph "1."

This rule is intended to implement Iowa Code section 502.305(9).

191—50.68(502) Delivery of prospectus. As a condition to registration by qualification pursuant to Iowa Code section 502.304, a prospectus containing the information required by Iowa Code section 502.304(2) shall be delivered to each person to which an offer is made, before or concurrently with the earliest of the following events:

1. The first offer made in a record to each person otherwise than by means of a public advertisement, by or for the account of the issuer or any other person on whose behalf the offering is made, or by any underwriter or broker-dealer offering part of an unsold allotment or subscription taken as a participant in the distribution;
2. The confirmation of any sale made by or for the account of the person;
3. The payment pursuant to any such sale; or
4. The delivery of the security pursuant to any such sale.

This rule is intended to implement Iowa Code section 502.304(5).

191—50.69(502) Advertisements.

50.69(1) The following advertising regarding the offer, sale or purchase of any security in Iowa is exempt from the filing requirements of Iowa Code section 502.504:

a. A prospectus published or circulated regarding an offering of a security registered pursuant to Iowa Code section 502.303 or 502.304 that is not yet effective, or an offering of a security for which a notice or application for exemption, including the prospectus, has been filed pursuant to Iowa Code section 502.201 or 502.202;

b. Advertising which provides information regarding only from whom a prospectus may be obtained, a description of the security offered for sale, the price of the security, or the names of broker-dealers having an interest in its sale;

c. Advertising published by a registered broker-dealer or investment adviser concerning the qualifications or business of the registrant, the general advisability of investing in securities or market quotations or other factual information relating to particular securities or issuers, provided the advertising contains no recommendation concerning the purchase or sale of a particular security;

d. Unless specifically requested by the administrator, advertising filed with the NASD or that satisfies the requirements of Securities Act of 1933 Rules 230.135a, 230.156, or 230.482; and

e. Any other advertising the administrator may specify by order.

50.69(2) All advertising required to be filed with the administrator by a registrant shall be filed prior to the date of use. All advertising required to be filed by a person other than a registrant shall be filed at least ten days prior to the date of use, or a shorter period if provided by the administrator. The advertising shall not be used in Iowa until the registrant receives approval from the administrator.

50.69(3) Sales literature of an investment company registered pursuant to the Investment Company Act of 1940 which is materially misleading within the meaning of rules or a statement of policy of the SEC constitutes false or misleading advertising as prohibited by Iowa Code section 502.504(2A).

50.69(4) False or misleading advertisements prohibited by Iowa Code section 502.504(2A) include, but are not limited to, the following:

a. Comparison charts or graphs showing a distorted, unfair, or unrealistic relationship between the issuer's past performance, progress, or success and that of another company, business, industry, or investment media;

b. Layout or format omitting information necessary to make the entire advertisement a fair and truthful representation;

c. Statements or representations without accreditation predicting future profit, success, appreciation, or performance, or otherwise addressing the merit or potential of the securities;

d. Generalizations, generalized conclusions, opinions, representations, and general statements based upon a particular set of facts and circumstances unless those facts and circumstances are stated and modified or explained by additional facts or circumstances as are necessary to make the entire advertisement a full, fair, and truthful representation;

e. Sales kits or film clips, displays or exposures, which alone or by sequence and progressive compilation present a misleading impression of guaranteed or exaggerated potential, profit, safety, or return;

f. Distribution of any nonfactual or inaccurate data or material by words, pictures, charts, or graphs, or otherwise based upon conjectural, unfounded, extravagant, or flamboyant claims, assertions, or predictions, or upon excessive optimism; and

g. Any package or bonus deal, prize, gimmick, or similar inducement regarding the offer or sale of a security that is combined with or dependent upon the sale of some other product, contract, or service unless the combination has been fully disclosed and specifically described and identified in the advertisement.

50.69(5) Any business card or other advertisement containing the name of an agent shall:

a. Clearly designate the agent as a securities agent or registered representative of the broker-dealer, as applicable, and indicate clearly that the broker-dealer is a broker-dealer;

b. Contain no advertising other than agent name, office address, broker-dealer name, and broker-dealer logo or trademark on the business cards;

c. Provide the office address and telephone number of the location where the agent conducts securities business; and

d. Clearly state the business of that entity and the relationship of the agent to that entity if the name, logo or trademark of any business entity other than that of the broker-dealer appears on the business card or in an advertisement.

50.69(6) A firm employing a sales agent who is offering securities on its behalf is responsible for ensuring that the name of the broker-dealer is displayed on the agent's business cards as prominently as the individual's name.

50.69(7) For the purpose of this rule, "advertisement" means any written or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, or other electronic communications media, published regarding the offer, sale, or purchase of a security.

This rule is intended to implement Iowa Code section 502.504.

191—50.70 to **50.79** Reserved.

DIVISION VI
EXEMPTIONS

191—50.80(502) Uniform limited offering exemption.

50.80(1) This rule is the NASAA Uniform Limited Offering Exemption as adopted in September 1983, with amendments adopted through April 29, 1989, without any of the footnotes and may be cited as the "Uniform Limited Offering Exemption."

a. Nothing in this exemption is intended to or should be in any way construed as relieving issuers or persons acting on behalf of issuers from providing disclosure to prospective investors adequate to satisfy the antifraud provisions of Iowa Code chapter 502 and these rules.

b. In view of the objective of this rule and the purposes and policies underlying Iowa Code chapter 502, the exemption is not available to any issuer for any transaction which, although in technical compliance with this rule, is part of a plan or scheme to evade registration or the conditions or limitations explicitly stated in this rule.

c. Nothing in this rule is intended to relieve registered broker-dealers or agents from the due diligence, suitability, "know your customer" standards, or any other requirements of law otherwise applicable to such registered persons.

50.80(2) Under the authority delegated to the administrator to promulgate rules by Iowa Code sections 502.203 and 502.605(1), the following transaction is exempt from the registration provisions of the Act:

a. Any offer or sale of securities offered or sold in compliance with the Securities Act of 1933, Regulation D, Rule 230.505, including any offer or sale made exempt by Rule 508(a), as made effective

in Release No. 33-6389 and as amended by Release Nos. 33-6437, 33-6663, 33-6758, and 33-6825, and which satisfies all of the following:

(1) No commission, fee or other remuneration shall be paid or given, directly or indirectly, to any person for soliciting any prospective purchaser in Iowa unless the person is registered under Iowa Code section 502.406 or is exempt from registration as a broker-dealer by Iowa Code section 502.401(2).

(2) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that the person receiving a commission, fee, or other remuneration was not appropriately registered in Iowa.

b. No exemption under this rule is available for the securities of any issuer if any of the parties described in the Securities Act of 1933, Regulation A, Rule 230.262(a), (b), or (c):

(1) Has filed a registration statement subject to a currently effective registration stop order entered under any state's securities law within five years prior to filing the notice required under this exemption;

(2) Has been convicted, within five years prior to filing the notice required under this exemption, of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to filing the notice required under this exemption, or is currently subject to any state's administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found and the order or judgment was entered within five years prior to filing the notice required under this exemption;

(4) Is currently subject to any state administrative enforcement order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities; or

(5) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or permanently restraining or enjoining the party from engaging in or continuing any conduct or practice regarding the purchase or sale of any security, or involving the making of any false filing with the state entered within five years prior to filing the notice required under this exemption.

(6) The disqualification of a person under paragraph 50.80(2)*"b"* may be waived by the administrator if the order, conviction, judgment or decree relating to the person's disqualification has been disclosed in writing to the administrator and the administrator has determined, for good cause shown, that the public interest no longer requires the person to be disqualified.

(7) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that a disqualification under this subrule existed.

c. The issuer shall file with the administrator a notice on Form D (17 CFR 239.500) not later than 15 days following the date of the first sale in Iowa. This notice shall be accompanied by:

(1) A copy of any written information furnished to investors;

(2) A Form U-2 consent to service of process; and

(3) A $100 filing fee.

d. Filing occurs on the earlier of:

(1) The date the notice is received by the administrator; or

(2) The date the documents are mailed with the United States Postal Service by registered or certified mail addressed to the administrator at the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066.

e. In all sales to nonaccredited investors in Iowa, one of the following conditions must be satisfied or the issuer and any person acting on its behalf shall have reasonable grounds to believe, and after making reasonable inquiry shall believe, that one of the following conditions is satisfied:

(1) The investment is suitable for the purchaser based upon facts, if any, disclosed by the purchaser regarding the purchaser's other security holdings, financial situation and needs. For this condition only, it is presumed that if the investment does not exceed 10 percent of the investor's net worth, it is suitable.

(2) The purchaser, either alone or with a purchaser's representative, has such knowledge and experience in financial and business matters that the purchaser is, or they are, capable of evaluating the merits and risks of the prospective investment.

50.80(3) The failure to comply with a term, condition or requirement of subparagraph 50.80(2)*"a"*(1), paragraph 50.80(2)*"c"* or paragraph 50.80(2)*"e"* will not result in loss of the exemption from the requirements of Iowa Code section 502.301 for any offer or sale to a particular individual or entity if the person relying on the exemption shows:

a. The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity;

b. The failure to comply was insignificant regarding the offering as a whole; and

c. A good-faith and reasonable attempt was made to comply with all applicable terms, conditions, and requirements of subparagraph 50.80(2)*"a"*(1), paragraph 50.80(2)*"c"* and paragraph 50.80(2)*"e."*

50.80(4) Where an exemption is established only through reliance upon subrule 50.80(3), the failure to comply is actionable under Iowa Code sections 502.603 and 502.604.

50.80(5) Transactions exempt under this rule may not be combined with offers and sales exempt under any other rule or provision of the Act. However, nothing in this limitation shall act as an election. Should for any reason the offer and sale fail to comply with all of the conditions for this exemption, the issuer may claim the availability of any other applicable exemption.

50.80(6) The administrator may, by rule or order, increase the number of purchasers or waive any other conditions of this exemption.

This rule is intended to implement Iowa Code section 502.203.

191—50.81(502) Notice filings for Rule 506 offerings.

50.81(1) An issuer offering a security that is a covered security pursuant to Section 18(b)(4)(D) of the Securities Act of 1933 shall submit no later than 15 days after the first sale of such federal covered security in Iowa:

a. A notice on Form D, including the Appendix;

b. A consent to service of process on Form U-2; and

c. A $100 filing fee, or a $250 fee for any late filing.

50.81(2) "SEC Form D," for the purposes of this rule, means the document, as adopted by the SEC and in effect on September 1, 1996, as may be amended by the SEC from time to time, entitled "FORM D: Notice of Sale of Securities pursuant to Regulation D, Section 4(6), and/or Uniform Limited Offering Exemption," including Part E and the Appendix.

This rule is intended to implement Iowa Code section 502.302(3).

191—50.82(502) Notice filings for agricultural cooperative associations.

50.82(1) An agricultural cooperative association issuing notes or other evidence of indebtedness shall notify the administrator in writing 30 days before the security is initially sold. Notification shall include:

a. The name of the issuer, the date of organization of the issuer, and the name of a contact person.

b. A description of the class of persons to whom the offer of securities will be made. If the offering is being made to certain persons or within a specified area, a description of such offerees or area shall be included.

c. A description of the type of security to be offered which includes information regarding interest and interest payment schedules, default, redemption, reinvestment, and other facts regarding the rights of holders that the issuer deems material to the offering.

d. Financial statements of the agricultural cooperative association including a balance sheet as of the end of its most recent fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor's report and any other audited financial statements of the

association that are available. However, if the filing by the agricultural cooperative association is made within 90 days of the end of its most recent fiscal year and current audited financial statements are not yet available, the filing may consist of an audited balance sheet and other available audited financial statements for the previous fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor's report. The agricultural cooperative association shall file an audited balance sheet and any other available audited financial statements for the most recent fiscal year end as soon as they become available, but in no event later than 90 days after the end of its fiscal year.

50.82(2) If, after the anniversary date of its initial notice filing, an agricultural cooperative association continues to issue notes or other evidence of indebtedness under its initial notice filing in order to maintain the exemption, the agricultural cooperative association shall on an annual basis file with the administrator an audited balance sheet and any other audited financial statements within 30 days of the anniversary of its initial notice filing. An agricultural cooperative association making its initial filing based upon a previous year's audited financial statements because of the unavailability of current audited financial statements shall consider its anniversary date to be the date on which the cooperative filed the audited financial statements for the most recent fiscal year. An agricultural cooperative association not issuing notes or other evidence of indebtedness after an anniversary date of its initial filing is not required to make any further filing of financial information as a condition of qualifying for the exemption from registration.

50.82(3) Form 1CP may be used to make the filing required by subrule 50.82(1). Form 1CP may be obtained by contacting the administrator at the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066; or via E-mail at iowa.sec@iid.state.ia.us.

This rule is intended to implement Iowa Code section 502.201(8B)*"b."*

191—50.83(502) Unsolicited order exemption.

50.83(1) Any unregistered broker-dealer effecting a transaction under an unsolicited order or offer to buy and claiming an exemption from registration based solely upon Iowa Code section 502.202(6) shall obtain acknowledgment from the customer on or before the settlement date of the transaction that the transaction is unsolicited.

50.83(2) The acknowledgment shall take one of the following forms:

a. A confirmation statement, as required pursuant to subrule 50.83(1), displaying in bold print on the face of the statement the words "Unsolicited Order, Notify Immediately if Otherwise"; or

b. A signed statement from the customer acknowledging that the order was unsolicited and containing the name of the customer, the name of the securities involved, the number of securities involved in the transaction, the purchase price of the securities, the transaction date, and the total dollar amount, including commissions paid, of the transaction.

50.83(3) The customer will be presumed to have acknowledged that the transaction was unsolicited if the customer does not indicate otherwise on or before the settlement date.

50.83(4) A broker-dealer shall notify the administrator in writing that it is executing unsolicited orders in a security when both of the following conditions are met:

a. More than six unsolicited orders or offers to buy such security are received during any three consecutive business days; and

b. The broker-dealer is relying solely upon the exemption provided by Iowa Code section 502.202(6).

This rule is intended to implement Iowa Code section 502.202(6).

191—50.84(502) Solicitation of interest exemption.

50.84(1) An offer, but not a sale, of a security made by or on behalf of an issuer for the sole purpose of soliciting an indication of interest in receiving a prospectus (or its equivalent) for such security is exempt from registration pursuant to Iowa Code section 502.301 if:

a. The issuer is or will be a business entity organized under the laws of one of the states or possessions of the United States or one of the provinces or territories of Canada, is engaged in or proposes to engage in a business other than petroleum exploration or production or mining or other extractive

industries, and is not a blind pool offering or other offering for which the specific business or properties cannot now be described.

b. The offerer intends to register the security in Iowa and conduct its offering pursuant to either Regulation A or Rule 504 of Regulation D, as promulgated by the SEC.

c. The offerer files with the administrator a SOIF along with any other materials to be used to conduct solicitations of interest including, but not limited to, the script of any broadcast to be made and a copy of any notice to be published no less than ten business days prior to the initial solicitation of interest.

d. The issuer files with the administrator all amendments to any materials filed pursuant to paragraph *"c"* or additional materials it proposes to use in conducting solicitations of interest, except for materials provided to a particular investor solely pursuant to a request by that investor, no less than five business days prior to use.

e. The offerer does not use any SOIF, script, advertisement, or other material which the administrator has ordered or notified the offerer may not be used for the purpose of solicitations of interest.

f. Except for scripted broadcasts and except to the extent necessary to obtain information needed to provide a SOIF, the offerer does not orally communicate with any prospective investor about the contemplated offering unless the investor is provided with the most current SOIF at or before the time of the communication or within five days after the communication.

g. The offerer does not solicit or accept money or a commitment to purchase securities during the solicitation of interest period.

h. The offerer does not make a sale until at least seven days after delivery to the purchaser of a final prospectus or delivery of a preliminary prospectus as provided by Iowa Code section 502.202(17).

50.84(2) Unless the offerer does not know, and in the exercise of reasonable care could not know, the exemption under this rule is not available for securities of an offerer, if any of the issuer's officers, directors, promoters, or 10 percent shareholders:

a. Have filed a registration statement which is the subject of a current effective registration stop order entered under any federal or state securities law within five years prior to filing the SOIF.

b. Have been convicted within five years prior to filing the SOIF of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud.

c. Are currently subject to any federal or state administrative enforcement order or judgment entered by any state securities administrator or the SEC within five years prior to filing the SOIF in which fraud or deceit, including, but not limited to, the making of untrue statements of material facts and omitting to state material facts, was found.

d. Are subject to any federal or state administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities.

e. Are currently subject to any order, judgment, or decree of any court of competent jurisdiction entered within five years prior to filing the SOIF temporarily, preliminarily, or permanently restraining or enjoining the person or entity from engaging in or continuing any conduct or practice regarding the purchase or sale of any security or the making of any false filing with any state.

The disqualifications listed in this subrule shall not apply if the person or entity subject to the disqualification is licensed or registered to conduct securities-related business in the state in which the administrative order or judgment was entered against the person or entity, or if the broker-dealer employing the person or entity is licensed or registered in Iowa and the Form BD filed with the administrator discloses the order, conviction, judgment, or decree. No person disqualified under this subrule may act in a capacity other than that for which the person is licensed or registered. Any disqualification caused by this subrule is automatically waived if the agency creating the disqualification determines for good cause shown that the exemption should not be denied.

50.84(3) The failure to comply with a term, condition or requirement of this rule shall not result in the loss of the exemption from the requirements of Iowa Code section 502.301 for an offer to a particular individual or entity if the offerer establishes all of the following:

a. The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity; and

b. The failure to comply was insignificant regarding the offering as a whole; and

c. A good-faith and reasonable attempt was made to comply with all applicable terms, conditions and requirements of this rule.

Where an exemption is established only through reliance upon subrule 50.84(2), the failure to comply is still actionable as a violation of the Act by the administrator under Iowa Code section 502.603 or 502.604.

50.84(4) The offerer shall comply with the following requirements:

a. Any published notice or script for broadcast and any printed material delivered apart from the SOIF, unless a SOIF containing the disclosures described below was previously delivered to the person, shall contain, at a minimum, the identity of the chief executive officer of the issuer, a brief and general description of the issuer's business and products, and the following disclosure printed in capital letters and boldface type at least as large as that used in the body of the printed materials:

(1) NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED.

(2) NO SALES OF SECURITIES WILL BE MADE OR A COMMITMENT TO PURCHASE ACCEPTED UNTIL THE DELIVERY OF AN OFFERING CIRCULAR THAT INCLUDES COMPLETE INFORMATION ABOUT THE ISSUER AND THE OFFERING.

(3) AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND.

(4) THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION UNDER FEDERAL AND STATE SECURITIES LAWS. NO SALE MAY BE MADE UNTIL THE OFFERING STATEMENT IS QUALIFIED BY THE U.S. SECURITIES AND EXCHANGE COMMISSION AND IS REGISTERED IN IOWA.

b. All communications with prospective investors made in reliance upon this rule shall cease after a registration statement is filed with the administrator, and no sale may be made until at least 20 calendar days after the last communication made in reliance upon this rule.

c. A preliminary prospectus may be used with an offering for which indications of interest have been solicited under this rule only if the offering is conducted by a registered broker-dealer.

Failure to comply with the requirements of this subrule shall not result in losing the exemption from the requirements of Iowa Code section 502.301, but is a violation of the Act, is actionable by the administrator under Iowa Code section 502.603 or 502.604, and constitutes grounds for denying or revoking the exemption for specific transactions.

50.84(5) Upon written application by the offerer and for good cause shown, the administrator may waive any condition of the solicitation of interest exemption. Neither compliance nor attempted compliance with this rule, nor the absence of any objection or order by the administrator regarding an offer of securities made under this rule, constitutes a waiver of any condition of the rule or a confirmation by the administrator of the availability of the rule.

50.84(6) Offers made in reliance upon this rule shall not be integrated with subsequent offers or sales of securities registered in Iowa. Issuers on whose behalf indications of interest are solicited under this rule may not make offers or sales in reliance upon Iowa Code section 502.202(14) or rule 191—50.80(502) until at least 12 months after the last communication with a prospective investor made pursuant to this rule.

50.84(7) Nothing in this rule limits the application of Iowa Code section 502.401, 502.402, 502.501 or 502.509 to offers made in reliance upon this rule.

50.84(8) The administrator may review the materials filed under this rule. Materials filed, if reviewed, will be judged under antifraud principles. Any discussion in the offering documents of the potential rewards of the investment must be balanced by a discussion of the possible risks.

50.84(9) Any offer effected in violation of this rule may constitute an unlawful offer of an unregistered security for which civil liability attaches under Iowa Code section 502.501 et seq. Any misrepresentation or omission may also give rise to civil liability under the Act. A subsequent

registration of the security does not cure the previous unlawful offer. Only a rescission offer made in compliance with the Act can effect a cure.

This rule is intended to implement Iowa Code section 502.202(17).

191—50.85(502) Internet offers exemption. Offers of securities made by, or on behalf of, issuers on or through the Internet are exempt from registration pursuant to Iowa Code sections 502.301 and 502.504 if:

1. The Internet offer states, directly or indirectly, that the securities are not being offered to state residents; and

2. The Internet offer is not specifically directed to any person in Iowa by, or on behalf of, the issuer of the securities; and

3. No sales of the issuer's securities are made in Iowa as a result of the Internet offering until such time as the securities being offered have been registered under Iowa Code sections 502.301 and 502.504, and a final prospectus or Form U-7 is delivered to Iowa investors prior to such sales, or the issuer qualifies for the exemption provided in Iowa Code section 502.202(13).

This rule is intended to implement Iowa Code section 502.203.

191—50.86(502) Denial, suspension, revocation, condition, or limitation of limited offering transaction exemption. The administrator shall view the following as reasons for entering an order under Iowa Code section 502.204 to deny or revoke an exemption provided under Iowa Code section 502.202(14):

1. A public advertisement is used to promote the sale of securities for which such exemption is claimed; or

2. The offering is part of a registered offering under the Securities Act of 1933.

This rule is intended to implement Iowa Code section 502.204.

191—50.87(502) Nonprofit securities exemption.

50.87(1) Church extension funds or similar organizations making continuous offerings shall be exempt pursuant to Iowa Code section 502.201(7)*"b"* provided the issuer:

a. Applies for the exemption;

b. Files an offering circular and otherwise substantially complies with the NASAA Statement of Policy Regarding Church Extension Funds as adopted by the NASAA membership on April 17, 1994, and amended by the NASAA membership on April 18, 2004, and published in CCH NASAA Reports at paragraph 1951;

c. Files all sales and advertising literature;

d. Files a consent to service of process;

e. After authorization, may sell securities for a period of 12 months; and

f. Upon the expiration of the 12-month period in paragraph *"e,"* files a renewal application that complies with the requirements of this subrule.

50.87(2) Church bonds and other one-time offerings for a single specific project shall be exempt pursuant to Iowa Code section 502.201(7)*"a"* provided the issuer:

a. Files a notice specifying the material terms of the offering that comply with the NASAA Statement of Policy Regarding Church Bonds as adopted by the NASAA membership on April 14, 2002, and published in CCH NASAA Reports at paragraph 1001; and

b. Files a consent to service of process.

This rule is intended to implement Iowa Code section 502.201(7).

191—50.88(502) Transactions with specified investors. The administrator grants the exemption for transactions with specified investors to the following persons:

50.88(1) Any director, executive officer, or general partner of the issuer of the securities being offered or sold, or any director, executive officer, or general partner of a general partner of that issuer.

50.88(2) Any natural person whose individual net worth, or joint net worth with that person's spouse, at the time of the purchase exceeds $1 million.

50.88(3) Any natural person who had an individual income in excess of $200,000 in each of the two most recent years or joint income with that person's spouse in excess of $300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year.

50.88(4) Any venture or seed capital company. For purposes of this subrule, a venture or seed capital company is a corporation, partnership or association that has been in existence for five years or whose net assets exceed $250,000 and whose primary business is investing in developmental stage companies or "eligible small business companies" as that term is defined in the regulations of the Small Business Administration.

This rule is intended to implement Iowa Code section 502.202(13).

191—50.89 to **50.99** Reserved.

DIVISION VII
FRAUD AND OTHER PROHIBITED CONDUCT

191—50.100(502) Fraudulent practices.

50.100(1) An issuer of securities registered under the Act, or any person who is an officer, director or controlling person of such issuer, is presumed to employ a "device, scheme or artifice to defraud" the purchasers of such securities under Iowa Code section 502.501(1) if such person applies, authorizes or causes to be applied any material part of the proceeds from the sale of such securities in any material way contrary to the purposes specified in the prospectus used in offering such securities and not reasonably related to the business of the issuer as described in the prospectus.

50.100(2) A broker-dealer or agent employing one or more of the following practices engages in an "act, practice, or course of business which operates or would operate as a fraud" under Iowa Code section 502.501(3):

a. Entering into any security transaction with a customer at an unreasonable price or at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit.

b. Contradicting or negating the importance of any information contained in a prospectus or other offering materials with intent to deceive or mislead or using any advertising or sales presentation in a deceptive or misleading manner.

c. In connection with the offer, sale, or purchase of a security, falsely leading a customer to believe that the broker-dealer or agent possesses material, nonpublic information impacting the value of the security.

d. In connection with the solicitation of a sale or purchase of a security, engaging in a pattern or practice of making contradictory recommendations to different investors of similar investment objectives for some to sell and others to purchase the same security, at or about the same time, when the recommendation is not justified by the particular circumstances of each investor.

e. Failing to make a bona fide public offering of all the securities allotted to a broker-dealer for distribution by, among other things, (1) transferring securities to a customer, another broker-dealer or a fictitious account with the understanding that those securities will be returned to the broker-dealer or its nominees, or (2) parking or withholding securities.

f. Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive or other fraudulent device or contrivance including, but not limited to, the use of "boiler-room" tactics such as repeated or harassing unsolicited telephone calls or the use of fictitious or nominee accounts.

50.100(3) Although nothing in this rule precludes applying the general antifraud provisions to any person who engages in practices similar to paragraphs *"a"* through *"h"* listed below, the listed practices apply only to soliciting a purchase or sale of OTC non-NASDAQ equity securities and excludes interests in direct participation programs and shares in open-end mutual funds:

a. Failing to disclose the entity's present bid and ask price of a particular security at the time of solicitation.

b. Failing to advise the customer, both at the time of solicitation and on confirmation, of the total of all charges and fees related to a specific securities transaction.

c. In connection with a principal transaction, failing to disclose, both at the time of solicitation and upon confirmation, a short inventory position in the entity's account of more than 5 percent of the issued and outstanding shares of that class of securities of the issuer, if the entity is a market maker at the time of solicitation.

d. Conducting sales contests in a particular security.

e. After a solicited purchase by a customer, failing or refusing, for a principal transaction, to promptly execute sell orders.

f. Refusing to sell existing securities held by the customer unless the customer executes a purchase transaction.

g. Soliciting a secondary market when there has not been a bona fide distribution in the primary market.

h. Engaging in a pattern of compensating an agent in different amounts for effecting sales and purchases in the same security.

This list is not intended to be all-inclusive. Engaging in other conduct including, but not limited to, forgery, embezzlement, conversion, nondisclosure, incomplete disclosure or misstatement of material facts may also be deemed fraudulent.

This rule is intended to implement Iowa Code section 502.501.

191—50.101(502) Rescission offers.

50.101(1) Rescission offers made pursuant to Iowa Code section 502.510 shall be typed or printed and shall be captioned "RESCISSION OFFER" in boldface print or type. The rescission offer shall be delivered to each offeree personally or shall be sent by certified mail to the offeree's last-known address and shall contain the following information:

a. The name of the security which is the subject of the offer.

b. A reasonably detailed statement indicating why liability under Iowa Code section 502.509 may have arisen and fairly and adequately advising the offeree of the offeree's rights pursuant to the Act.

c. An offer to repurchase the security pursuant to Iowa Code section 502.510(1)*"b"* to *"f,"* as applicable.

d. A statement that the offeree's right to bring an action under the Act may be lost unless the offeree accepts the offer within 30 days after receiving the offer, or any shorter period, of not less than three days, that the administrator, by order, specifies.

e. Sufficient information about the issuer and the security offered to permit the offeree to make an informed decision regarding acceptance of the rescission offer including, but not limited to, information about the issuer's organization and management, its operations and plan of business, and its financial condition as shown by a current financial statement prepared under generally accepted accounting principles.

f. A form by which the offeree may accept the offer and a statement explaining that the offeree may accept the offer by returning the form to the offerer at the provided address by first-class mail, or any other type of mail.

g. If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would operate as a fraud or deceit on another person, in capital letters and boldface type at least as large as that used in the body of the printed materials, and placed immediately before the signature of the offerer, the following statement:

THIS IS A RESCISSION OFFER MADE PURSUANT TO IOWA CODE SECTION 502.510, A COPY OF WHICH IS ON FILE WITH THE IOWA SECURITIES AND REGULATED INDUSTRIES BUREAU. THE BUREAU MAKES NO RECOMMENDATION AS TO WHETHER THE OFFER SHOULD BE ACCEPTED OR REJECTED NOR HAS THE BUREAU PASSED UPON THE ADEQUACY OR ACCURACY OF THIS OFFER.

50.101(2) If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would operate as a fraud or deceit on another person, prior to making a rescission offer pursuant to Iowa Code section 502.510, the offerer shall file with the administrator:

a. A copy of the rescission offer;

b. The names and addresses of all holders or sellers who are to receive the rescission offer; and

c. Financial statements proving that the offerer's assets are sufficient to meet its obligations should all offerees accept the rescission offer.

50.101(3) Rescission offers made pursuant to Iowa Code section 502.510 shall be tendered to all persons to whom liability exists or may exist pursuant to Iowa Code section 502.509.

50.101(4) A rescission offer may be accepted at any time during the period stated in the rescission offer even if an offeree previously rejected the offer.

50.101(5) Rescission offers are subject to the provisions of Iowa Code sections 502.501, 502.501A, 502.505, 502.506, and 502.506A.

50.101(6) The administrator may, in the administrator's discretion, require proof by the offerer of compliance with this rule and the terms of the rescission offer.

50.101(7) A proposal or the making of a rescission offer shall not limit the administrator's administrative or enforcement authority provided by the Act.

This rule is intended to implement Iowa Code sections 502.509 and 502.510.

191—50.102(502) Fraudulent, deceptive or manipulative act, practice, or course of business in providing investment advice.

50.102(1) It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative acting as principal for such person's own account, knowingly to sell any security to or purchase any security from a client or, acting as broker for a person other than such client, knowingly to effect any sale or purchase of any security for the account of such client, without disclosing to such client in writing before the completion of such transaction the capacity in which the investment adviser is acting and obtaining the consent of the client to such transaction. The prohibitions of this subrule shall not apply to any transaction with a customer of a broker-dealer if such broker-dealer is not acting as an investment adviser in relation to such transaction.

50.102(2) It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative to fail to disclose to any client or prospective client all material facts regarding financial and disciplinary information as provided in 17 CFR Section 275.206(4)-4.

50.102(3) Pooled investment vehicles.

a. It shall constitute a fraudulent, deceptive, or manipulative act, practice, or course of business within the meaning of Iowa Code section 502.502(2) for any investment adviser to a pooled investment vehicle to:

(1) Make any untrue statement of a material fact or to omit to state a material fact necessary to make the statements made, in the light of the circumstances under which they were made, not misleading, to any investor or prospective investor in the pooled investment vehicle; or

(2) Otherwise engage in any act, practice, or course of business that is fraudulent, deceptive, or manipulative with respect to any investor or prospective investor in the pooled investment vehicle.

b. For purposes of this subrule, "pooled investment vehicle" means any investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-3(a)) or any company

that would be an investment company under Section 3(a) of that Act but for the exclusion provided from that definition by either Section 3(c)(1) or Section 3(c)(7) of that Act (15 U.S.C. 80a-3(c)(1) or (7)).

This rule is intended to implement Iowa Code section 502.502(2).

191—50.103(502) Investment advisory contracts.

50.103(1) It is unlawful for any investment adviser to enter into, extend, or renew any investment advisory contract unless the contract provides in writing all of the following:

a. That the investment adviser shall not be compensated on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client.

b. That no assignment of the contract may be made by the investment adviser without the consent of the other party to the contract.

c. That the investment adviser, if a partnership, shall notify the other party to the contract of any change in the membership of the partnership within a reasonable time after the change.

50.103(2) The provisions of subrule 50.103(1) shall be construed consistent with Sections 205(b) through (d) of the Investment Advisers Act of 1940, the terms of which shall be defined by Investment Advisers Act of 1940 Rules 275.205-1 and 275.205-2.

50.103(3) The provisions of subrule 50.103(1) shall not prohibit compensation on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client in compliance with the exemption in 17 CFR Section 275.205-3.

This rule is intended to implement Iowa Code section 502.502(3).

191—50.104 to **50.109** Reserved.

DIVISION VIII
VIATICAL SETTLEMENT INVESTMENT CONTRACTS

191—50.110(502) Application by viatical settlement investment contract issuers and registration of agents to sell viatical settlement investment contracts.

50.110(1) Under this rule, the term "viatical settlement investment contract issuer" includes, but is not limited to, any individual, company, corporation or other entity that offers or sells, directly or indirectly, viatical settlement investment contracts to investors.

50.110(2) A viatical settlement investment contract issuer employing agents in Iowa must make prior application to the administrator for this authority. The application shall be made by letter and shall include:

a. A statement of the issuer's intent to employ agents for the sale of its viatical settlement investment contracts; and

b. The name, address, social security number and proof of satisfaction of subrule 50.110(3) for each agent.

50.110(3) An applicant for registration as an Iowa-registered agent of an issuer of viatical settlement investment contracts shall file with the administrator:

a. Proof of obtaining a passing grade on the NASD Series 7 examination;

b. Proof of obtaining a passing grade on the NASD Series 63 examination;

c. An accurate, complete and signed Form U-4; and

d. A $30 filing fee.

This rule is intended to implement Iowa Code sections 502.102(2), 502.301 and 502.402.

191—50.111(502) Risk disclosure. Viatical settlement investment contract issuers and registered agents of issuers must provide specific, written disclosures of risk to Iowa investors at the time of the initial offer to sell a viatical settlement investment contract. These disclosures must be preceded by the following caption, which must be in bold, 16-point typeface:

IMPORTANT RISK DISCLOSURE INFORMATION—READ BEFORE SIGNING ANY
VIATICAL SETTLEMENT INVESTMENT CONTRACT.

The disclosure must include, at a minimum, the following information:

1. That the actual annual rate of return on any viatical settlement investment contract is dependent upon an accurate projection of the viator's life expectancy and the actual date of the viator's death and that an annual "guaranteed" rate of return is not possible;

2. Whether, after purchasing the viatical settlement investment contract, the investor will be responsible for payment of premiums on the contract if the viator lives longer than projected and if the investor will be responsible for such premiums, the amount of the premium payment and any resulting negative effect on the investor's return;

3. Whether any premium payments on the contract have been escrowed and, if so, the date upon which the escrowed funds will be depleted, who is responsible for payment of premiums after depletion of the funds, and, if applicable, the amount of the premiums;

4. Whether any premium payments on the contract have been waived, whether the investor will be responsible for payment of the premiums if the insurer who wrote the policy terminates the waiver after purchase, and, if applicable, the amount of the premiums;

5. Whether the investor is responsible for payment of premiums on the contract if the viator returns to health and, if applicable, the amount of the premiums;

6. Whether the investor is entitled to all or part of the investor's investment under the contract if the viator's underlying policy is later determined to be null and void;

7. Whether the insurance policy is a group policy and, if so, the special risks associated with group policies including, but not limited to, whether the investor is responsible for payment of additional premiums if the policies are sold or converted;

8. Whether the insurance policy is term insurance and, if so, the special risks associated with term insurance including, but not limited to, whether the investor is responsible for additional premium costs if the viator continues the term policy at the end of the current term;

9. Whether the investor will be the beneficiary or owner of the insurance policy and, if the investor is the beneficiary, the special risks associated with beneficiary status;

10. Whether the insurance policy is contestable and, if so, the special risks associated with contestability including, but not limited to, the risk that the investor will have no claim or only a partial claim to death benefits should the insurer cancel the policy within the contestability period;

11. Who is making the projection of the viator's life expectancy, the information upon which the projection is based, and the relationship of the projection maker to the issuer;

12. Who is monitoring the viator's condition, how often the monitoring is done, how the date of death is determined, and how and when this information will be transmitted to the investor;

13. Whether the insurer who wrote the viator's underlying policy has any additional rights which could negatively affect or extinguish the investor's rights under the viatical settlement investment contract, what these rights are, and under what conditions these rights are activated;

14. That a viatical settlement investment contract is not a liquid investment and that there is no established secondary market for resale of these products by the investor;

15. That the investor will receive no returns (i.e., dividends and interest) until the viator dies; and

16. That the investor may lose all benefits or receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

This rule is intended to implement Iowa Code sections 502.102, 502.201(9E) and 502.301.

191—50.112(502) Advertising of viatical settlement investment contracts.

50.112(1) The issuer and agent shall file all viatical settlement investment contract advertisements with the administrator at least ten business days prior to the date of use or a shorter period as the administrator may permit. The administrator shall mark the advertisements with allowance for use or expressly disapprove them during this time frame. The advertisement shall not be used in Iowa until a copy thereof, marked with allowance for use, has been received from the administrator.

50.112(2) Viatical settlement investment contract advertisements shall contain no more than the following:

a. The name of the issuer;

b. The address and telephone number of the issuer;

c. A brief description of the security, including minimum purchase requirements and liquidity aspects;

d. If a rate of return is advertised, it must be stated as the annual average rate of return, with a disclaimer that this is an annual average rate of return, that individual investor rates of return will vary based upon the viator's projected and actual date of death, and that an annual rate of return on a viatical settlement investment contract cannot be guaranteed;

e. The name, address and telephone number of the agent of the issuer authorized to sell the viatical settlement investment contracts;

f. A statement that the advertisement is neither an offer to sell nor a solicitation of an offer to purchase and that any offer or solicitation may only be made by providing a disclosure document; and

g. How a copy of the disclosure document may be obtained.

50.112(3) Notwithstanding the provisions of rule 191—50.69(502), certain viatical settlement investment contract advertisements may be deemed false and misleading on their face by the administrator and are prohibited pursuant to Iowa Code sections 502.501 and 502.504. False and misleading viatical settlement investment contract advertisements include, but are not limited to, the following representations:

a. "Fully secured," "100% secured," "fully insured," "secure," "safe," "backed by rated insurance company(ies)," "backed by federal law," "backed by state law," or similar representations;

b. "No risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;

c. "Qualified or approved for IRA, Roth IRA, 401K, SEP, 403B, Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;

d. "Guaranteed fixed return," "guaranteed annual return," "guaranteed principal," "guaranteed earnings," "guaranteed profits," "guaranteed investment," or similar representations;

e. "No sales charges or fees" or similar representations;

f. "High yield," "superior return," "excellent return," "high return," "quick profit," or similar representations;

g. "Perfect investment," "proven investment," or similar representations;

h. Purported favorable representations or testimonials about the benefits of viaticals as an investment, taken out of context from newspapers, trade papers, journals, radio or television programs, or any other form of print or electronic media.

50.112(4) For purposes of this rule, the term "advertisement" includes any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including filmstrips, motion pictures, and videos, published in connection with the offer or sale of a viatical settlement investment contract.

This rule is intended to implement Iowa Code sections 502.102, 502.301, and 502.504.

191—50.113(502) Duty to disclose. Issuers and agents equally share an affirmative duty to disclose all relevant and material information to prospective investors in viatical settlement investment contracts. The required disclosure is the registration statement required by Iowa Code section 502.304 which has been reviewed and made effective by the administrator.

This rule is intended to implement Iowa Code sections 502.102 and 502.201(9E).

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◊ Two or more ARCs

[1] Objection to rules 50.19 and 50.44, see IAC Supplement 3/8/76

CHAPTERS 51 to 53
Reserved

CHAPTER 54
RESIDENTIAL SERVICE CONTRACTS

191—54.1(523C) Purpose. The following chapter is promulgated for the purpose of administering the provisions of Iowa Code chapter 523C, the Iowa residential service contracts Act, relating to contracts or agreements between a residential customer and a service company which undertakes, for a predetermined fee and for a specified period of time, to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems of residential property containing not more than four dwelling units.

191—54.2(523C) Definitions. As used in the Act and this chapter, unless the context otherwise requires:

"Act" means Iowa Code chapter 523C, the Iowa residential service contracts Act.

"Commission" means the insurance division of the state of Iowa.

"Commissioner" means the commissioner of insurance for the state of Iowa.

"Guarantee or warranty" means:

1. Any written affirmation or written promise made by a manufacturer or seller in connection with the sale of structural components or any tangible personal property which relates to the nature of the material or workmanship and affirms or promises that the material or workmanship is free of defects or will meet a specified level of performance over a specified period of time; or

2. Any undertaking by a manufacturer or seller made in writing in connection with the sale of structural components or any tangible personal property to refund, repair, replace or take other remedial action with respect to a product if the product fails to meet the specifications set forth in the undertaking, which written affirmation, promise or undertaking becomes part of the basis of the bargain for purposes other than resale.

"Licensed service company" means a service company which is licensed by the Iowa securities bureau pursuant to this Act.

"Net worth" means the excess of all assets over all liabilities including required reserves, computed in accordance with generally accepted accounting principles.

"Person" means an individual, corporation, trust, partnership or association, or any other legal entity.

"Residential customer" means any person (whether or not the person is the owner of the residential property) who purchases a service contract relating to a residential property from a service company.

"Residential property" means any single or multiple unit structure, including a house, townhouse, condominium, mobile home, or other habitable structure which is used primarily for residential purposes.

"Residential service contract" means a contract or agreement between a residential customer and a service company which undertakes, for a predetermined fee and for a specified period of time, to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems of residential property containing not more than four dwelling units.

"Service company" means a person who issues and performs, or arranges to perform, services pursuant to a residential service contract.

"Service contract" means a contract or agreement between a customer and a service company which undertakes, for a predetermined fee and for a specified period of time, to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems intended to be attached to or installed in or on real property.

"Structural components" means the roof, foundation, basement, walls, ceiling or floors of a residential property.

191—54.3(523C) Title. The Act may be cited as the "Iowa residential service contracts Act."

191—54.4(523C) Scope.

54.4(1) This chapter shall apply to any contract or agreement between a residential customer and a service company which undertakes, for a predetermined fee and for a specified period of time,

to maintain, repair, or replace all or any part of the structural components, appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems of residential property containing not more than four dwelling units.

54.4(2) This chapter shall apply when an agreement is made in this state or any offer to sell a residential service contract is made or accepted in this state. An offer to sell is made in this state, whether or not either party is then present in this state, when the offer originates from this state or is directed by the offeror to this state and received by the offeree in this state.

191—54.5(523C) Application of insurance laws. The sale of a residential service contract by a licensed service company shall not be deemed to include the sale of insurance. Thus, unless the service company is otherwise engaged in the sale of insurance, the provisions of the insurance laws of this state shall not be applicable to any service company granted a license under the Act. However, this provision may not be construed to exempt any other warranties or service contracts other than residential service contracts, as defined herein, from the provisions of the insurance laws of this state.

191—54.6(523C) Exemptions. The provisions of the Act and this chapter do not apply to the following:

54.6(1) A performance guarantee given by a builder of a residence or the manufacturer or seller or lessor of residential property if no identifiable charge is made for the guarantee.

54.6(2) A service contract, guarantee or warranty between a residential customer and a service company which will perform the work itself and not through subcontractors for the service, repair or replacement of appliances or electrical, plumbing, heating, cooling or air-conditioning systems.

54.6(3) A contract between a service company and a person who actually performs the maintenance, repairs, or replacements of structural components, or appliances, or electrical, plumbing, heating, cooling, or air-conditioning systems, if someone other than the service company actually performs these functions.

54.6(4) A service contract, guarantee or warranty issued by a retail merchant to a retail customer, guaranteeing or warranting the repair, service or replacement of appliances or electrical, plumbing, heating, cooling or air-conditioning systems sold by the retail merchant.

191—54.7 to **54.9** Reserved.

191—54.10(523C) Administration.

54.10(1) The Act shall be administered by the commissioner of insurance of the state of Iowa. As deputy administrator, the Iowa superintendent of securities shall be the principal operations officer responsible to the commissioner for the routine administration of the Act and management of the administrative staff of the Iowa securities bureau.

54.10(2) In the absence of the commissioner, whether because of vacancy in the office, by reason of absence, physical disability or other cause, the superintendent of securities shall be the acting administrator and shall, for the time being, have and exercise the authority conferred upon the commissioner. The commissioner may from time to time delegate to the superintendent of securities any or all of the functions assigned to the commissioner in the Act.

54.10(3) The superintendent of securities shall employ officers, attorneys, accountants, investigators, and other employees as shall be needed for the administration of the Act.

54.10(4) Upon request the commissioner may honor requests from interested persons for interpretative opinions.

191—54.11(523C) Misrepresentations of government approval.

54.11(1) It is unlawful for any service company granted a license under the Act to represent or imply in any manner that the licensee has been sponsored or recommended or that the licensee's abilities or qualifications have in any respect been passed upon by the Iowa securities bureau, the Iowa insurance division or the state of Iowa.

54.11(2) Nothing in this regulation prohibits a statement other than in a paid advertisement that a person has received a license pursuant to the Act, if the statement is true in fact and if the effect of the license's issuance is not misrepresented.

191—54.12(523C) Public access to hearings. Every hearing in an administrative proceeding shall be public.

191—54.13(523C) Public access to records.

54.13(1) The commissioner shall keep a register of all applications for licenses which are or have been effective under the Act and all censure, denial, suspension or revocation orders which have been entered under the Act. The register shall be open for public inspection.

54.13(2) Upon request and at reasonable charges the commissioner shall furnish to any person photostatic or other copies, certified if requested, of any entry in the register or any document which is a matter of public record. In any administrative proceeding or prosecution under the Act, any copy so certified is prima facie evidence of the contents of the entry or document certified.

54.13(3) Except as provided in the following subrule, all records maintained by the commissioner pursuant to the Act shall be a matter of public record and shall be made available for inspection or copying.

54.13(4) The commissioner may keep confidential certain information obtained in the course of an investigation or audit pursuant to Iowa Code chapter 22 as follows:

a. Information consisting of records which represent and constitute the work product of an attorney, which is related to litigation or claim made by or against a public body;

b. Information consisting of a peace officer's investigation report; provided, however, that the date, time, specific location, and immediate facts and circumstances surrounding a crime or incident shall not be kept confidential except in those unusual circumstances where disclosure would plainly and seriously jeopardize an investigation or pose a clear and present danger to the safety of an individual; or

c. Information consisting of a report to a governmental agency which, if released, would give advantage to competitors and serve no public purpose.

d. Information consisting of communications not required by law, rule, or procedure made to the insurance division or to any of its employees by identified persons outside of government, to the extent that the division could reasonably believe that those persons would be discouraged from making them if they were available for general public examination. Notwithstanding this provision:

(1) The communication is a public record to the extent that the person outside of the government making that communication consents to its treatment as a public record.

(2) Information contained in the communication is a public record to the extent that it can be disclosed without directly or indirectly indicating the identity of the person outside of government making it or enabling others to ascertain the identity of that person.

(3) Information contained in the communication is a public record to the extent that it indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act, except to the extent that its disclosure would plainly and seriously jeopardize a continuing investigation or pose a clear and present danger to the safety of any person. In any action challenging the failure of the insurance division to disclose any particular information of the kind enumerated in this paragraph, the burden of proof is on the insurance division to demonstrate that the disclosure of that information would jeopardize an investigation or would pose a clear and present danger.

54.13(5) If the commissioner determines that it is necessary or appropriate, in the public interest, the commissioner may share information with other administrators, regulatory authorities, or governmental agencies or may publish information concerning a violation of the Act, this chapter, or an order issued pursuant to the Act or this chapter.

191—54.14(523C) Procedure for public complaints.

54.14(1) The commissioner may receive and process complaints made against any licensee, or any unlicensed individual or entity, which alleges certain acts or practices which may constitute one or more violations of the provisions of Iowa Code chapter 523C, the Iowa residential service contracts Act or this chapter. Any member of the public, or any federal, state, or local officials, may make and file a complaint with the commissioner. Complaints may be received from sources outside the state of Iowa and processed in the same manner as those originating in Iowa.

54.14(2) Complaints may be mailed or delivered to the following address: Iowa Securities Bureau, Lucas State Office Building, Des Moines, Iowa 50319.

54.14(3) All complaints shall be in writing and shall fully identify the complainant by name and address. If required by the Iowa securities bureau, complaints shall be made on forms prescribed and provided by that bureau.

54.14(4) Oral or telephone communications will not be considered or processed as complaints. However, any member of the administrative staff of the commissioner may make and file a complaint based upon information and belief, in reliance upon oral, telephone, or written communications received by the office of the commissioner.

191—54.15(523C) Fees.

54.15(1) The following fees are hereby established by the commissioner:

a.	Application packet	$ 5.00
b.	Audit fee (salaries and overhead)	At Cost
c.	Certification	$ 5.00
d.	Duplicate license	$ 5.00
e.	Form approval fee	$ 100.00
f.	Form review fee (3% — MINIMUM)	$ 100.00
g.	License fee	$ 250.00
h.	License renewal fee	$ 250.00
i.	Name change	$ 10.00
j.	Photocopies of records (per page)	$ 0.50
k.	Printout of licensees	$ 10.00

54.15(2) A notice of license denial, or a notice of denial concerning a license renewal, shall be accompanied by a refund of 50 percent of the fee submitted with the application. All of the other fees are nonrefundable.

191—54.16(523C) Forms.

54.16(1) *Content.* Copies of all necessary forms and instructions may be obtained from the Iowa Securities Bureau, Lucas State Office Building, Des Moines, Iowa 50319. The list which follows describes the forms which members of the public shall use when dealing with the bureau. Each direction shall be complied with and each question in the forms shall be answered in the same manner as if the forms and instructions were embodied in these rules.

FORM NUMBER	DESCRIPTION
R-1	Application For Service Company License. Used by applicants when filing for the issuance or renewal of a service company license under the Act.
R-2	Affidavit Stating Satisfactory Net Worth and the Number of Contracts Issued. Used by applicants when filing for the issuance or renewal of a service company license under the Act, it constitutes Exhibit A of Form R-1.

FORM NUMBER	DESCRIPTION
R-3	Affidavit Attesting to Reserve Account Balance. Used by applicants when filing for the issuance or renewal of a service company license under the Act, it constitutes Exhibit B of Form R-1.
R-4	Surety Bond. Form of surety bond that must be filed prior to the issuance or renewal of a license.
R-5	Annual Report. Used by licensees when filing their annual report under the Act.
R-6	License Form.

54.16(2) *Cost.* The forms listed above are available upon request at reasonable charges prescribed by the commissioner. An application packet, containing one copy each of the Act, this chapter and all of the application and report forms, shall be available for a $5 charge. Individual forms may be acquired as follows:

FORM NUMBER	QUANTITY	COST
R-1	10	$1.00
R-2	10	$1.00
R-3	10	$1.00
R-4	10	$1.00
R-5	10	$1.00
R-6	10	$1.00

191—54.17 to **54.19** Reserved.

191—54.20(523C) Service company licenses. A person shall not issue a residential service contract or undertake or arrange to perform services pursuant to a residential service contract unless the person is a corporation, limited liability company, partnership or limited liability partnership and has procured a service company license from the Iowa securities bureau.

191—54.21(523C) Suspension or revocation of license.

54.21(1) The commissioner may suspend or revoke or refuse to renew the license of a service company for any of the following grounds:

a. The service company violated a lawful order of the commission or any provision of the Act.

b. The service company failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final.

c. The service company has without just cause refused to perform or negligently or incompetently performed services required to be performed under its residential service contracts and the refusal, or negligent or incompetent performance has occurred with such frequency, as the commissioner determines, as to indicate the general business practices of the service company.

d. The service company has engaged in a prohibited act or practice prohibited by this chapter.

e. The service company failed to maintain the surety bond required by Iowa Code section 523C.5.

f. The service company failed to maintain the net worth required by Iowa Code section 523C.6.

g. The service company failed to maintain the reserve account required by Iowa Code section 523C.11.

h. The service company failed to maintain its corporate certificate of good standing.

54.21(2) Procedure. 191—Chapter 3 of the Iowa insurance division's administrative rules, entitled "Administrative Hearings of Contested Cases," in the Iowa Administrative Code shall govern the

practice, procedure and conduct of informal proceedings, contested case proceedings, reviews, and licensing.

191—54.22(523C) Licenses not transferable. Service company licenses shall not be transferable. A service company which sells its business shall cancel its service company license and the purchaser of the business shall apply for a new license in their own name.

191—54.23 to **54.29** Reserved.

191—54.30(523C) Forms of contracts.

54.30(1) A residential service contract shall not be issued or used in this state unless it has been filed with the Iowa securities bureau and approved by the commissioner. If the commissioner fails to inform the service company of objections to the forms of residential service contracts within 30 days after filing, the residential contract shall be deemed to have been approved by the commissioner provided it otherwise complies with Iowa Code section 523C.7.

54.30(2) A form approval fee of $100 shall be submitted for each form of contract filed with the Iowa securities bureau, unless the form of contract is filed with the annual report.

191—54.31 to **54.39** Reserved.

191—54.40(523C) Cessation of business—records. A licensed service company discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to contract holders in this state.

191—54.41(523C) Records.

54.41(1) All licensed service companies and independent depositories shall keep accurate accounts, books, and records concerning transactions regulated under the Act.

54.41(2) A licensed service company's accounts, books, and records shall include:

a. Copies of all contracts;

b. The name and address of each residential customer;

c. The name and address of each independent depository; and

d. The dates and amounts of all receipts and expenditures.

54.41(3) A licensed service company shall retain all required accounts, books, and records pertaining to each residential service contract for at least two years after the specified period of time has expired.

54.41(4) All licensed service companies and independent depositories shall make all accounts, books, and records concerning transactions regulated under the Act available to the commissioner for the purpose of examination.

191—54.42(523C) Annual reports.

54.42(1) A licensed service company shall file with the Iowa securities bureau an annual report on the forms prescribed by the commissioner within 90 days of the close of its fiscal year.

54.42(2) One copy of each residential service contract to be issued or used in this state shall be filed for review as an exhibit(s) to the annual report and the licensed service company shall pay a form review fee of 3 percent of the aggregate amount of residential service contract fees received in the state of Iowa during the preceding fiscal year, but the fee shall in no case be less than $100.

54.42(3) Using the information obtained in the annual reports and any additional information requested by the commissioner, the commissioner shall evaluate the fees charged for the residential service contract to determine if they are reasonable in relation to the value of the claims made. The commissioner may order an adjustment of the fees if the commissioner determines that the fees are not reasonable in relation to the value of the claims made.

191—54.43 to **54.49** Reserved.

191—54.50(523C) Prohibited acts or practices.

54.50(1) *Defamation.* A licensed service company is hereby prohibited from making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure that person.

54.50(2) *Boycott, coercion, and intimidation.* A licensed service company is prohibited from entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the service contract industry.

54.50(3) *False statements.* A licensed service company is prohibited from knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

54.50(4) *False entries.* A licensed service company is prohibited from knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of that person in any book, report or statement of that person.

54.50(5) *Misrepresentation, false advertising, and unfair practices.*

a. Unless licensed as an insurance company, a licensed service company may not use in its name, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation, or any other service company.

b. A licensed service company may not:

(1) Without the written consent of the residential customer, knowingly charge a residential customer for duplication of coverage or duties required by state or federal law, a warranty expressly issued by a manufacturer or seller of a product or any implied warranty enforceable against the lessor, seller or manufacturer of a product.

(2) Make, permit or cause any false or misleading statements, either oral or written, in connection with the sale, offer to sell or advertisement of a residential service contract.

(3) Permit or cause the omission of any material statement in connection with the sale, offer to sell or advertisement of a residential service contract, which under the circumstances should have been made in order to make the statements that were made not misleading.

(4) Make, permit or cause any false or misleading statements, either oral or written, about the benefits or services available under the residential service contract.

(5) Make, permit or cause any statement or practice which has the effect of creating or maintaining a fraud.

(6) Make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation, or statement with respect to the service contract industry or with respect to any service company which is untrue, deceptive or misleading.

c. A bank, savings and loan association, insurance company or other lending institution shall not require the purchase of a residential service contract as a condition of a loan and shall not sell a residential service contract to a borrower unless the borrower signs an affidavit acknowledging that the purchase is not required.

191—54.51(523C) Orders. The commissioner may, by order, take actions which are necessary or appropriate for the protection of residential customers and to implement the purposes of the Act.

191—54.52(523C) Investigations and subpoenas.

54.52(1) The commissioner may:

a. Make private and public investigations within or outside of this state as the commissioner deems necessary to determine whether a person has violated any provision of the Act or any rule or order under it or to aid in the enforcement of the Act;

b. Require or permit any person to file a statement under oath or otherwise as the commissioner determines as to all of the facts and circumstances concerning the matter to be investigated; and

c. Publish information concerning any violation of the Act or any rule or order under it.

54.52(2) For the purpose of any investigation or proceeding under the Act, the commissioner, or any officer designated by the commissioner may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the commissioner deems relevant or material to the inquiry.

54.52(3) No person is excused from attending and testifying or from producing any document or record before the commissioner or in obedience to a subpoena of the commissioner on the grounds that the testimony or evidence, documentary or otherwise, required of that person may tend to incriminate or subject that person to a penalty or forfeiture; but no individual may be prosecuted or subject to any penalty or forfeiture on account of any transaction, matter, or thing concerning which that person is compelled after claiming privilege against self-incrimination to testify or produce evidence, documentary or otherwise, except that the individual testifying is not exempt from prosecution for perjury or contempt committed in testifying.

191—54.53(523C) Audits.

54.53(1) The commissioner shall have the right to examine or cause to be examined the books, papers, records, memoranda or documents of a licensed service company for the purpose of verifying compliance with the Act and this chapter. When a licensee fails or refuses to produce the records for examination when requested by the commissioner, the commissioner shall have the authority to require, by a subpoena, the attendance of the licensee, or its representative, and any other witness(es) whom the commissioner deems necessary or expedient to examine and compel the licensee and witness(es) to produce books, papers, records, memoranda or documents relating in any manner to compliance with the Act or this chapter.

54.53(2) Unless waived by the commissioner, the audit shall be paid for by the licensed service company.

These rules are intended to implement Iowa Code chapter 523C.

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CHAPTER 55
LICENSING OF PUBLIC ADJUSTERS

191—55.1(82GA,HF499) Purpose. The purpose of this chapter is to govern the qualifications and procedures for licensing public adjusters in this state and to specify the duties of and restrictions on public adjusters, including limitation of such licensure to assisting only insureds with first-party claims.

191—55.2(82GA,HF499) Definitions. As used in this chapter, unless the context otherwise requires:

"Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or any other legal entity.

"Catastrophic disaster," according to the Federal Response Plan, means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; and severely affects state, local and private sector capabilities to begin and sustain response activities. A catastrophic disaster shall be declared by the President of the United States or the governor of the state or district in which the disaster occurred.

"Commissioner" means the Iowa insurance commissioner.

"Division" means the Iowa insurance division.

"Fingerprints" means an electronic impression of the lines on a human finger taken for the purposes of identification.

"First-party claim" means a claim filed by a person insured under the insurance policy against which the claim is made.

"Home state" means the District of Columbia and any state or territory of the United States in which the public adjuster's principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the "home state."

"Individual" means a natural person.

"Insured" means a person insured under the insurance policy against which the claim is made.

"NAIC" means the National Association of Insurance Commissioners.

"NIPR Gateway" means the communication network developed and operated by the National Insurance Producer Registry that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of, among other things, public adjuster information regarding license applications, license renewals, appointments and terminations. The National Insurance Producer Registry is a nonprofit affiliate of the NAIC. The NIPR's Web site is www.licenseregistry.com.

"Person" means an individual or a business entity.

"Producer database" means the national database of insurance producers maintained by the NAIC.

"Public adjuster" means any person who, for compensation or any other thing of value, acts on behalf of an insured by doing any of the following:

1. Acting for or aiding an insured in negotiating for or in effecting the settlement of a first-party claim for loss or damage to real or personal property of the insured.
2. Advertising for employment as a public adjuster of first-party claims or otherwise soliciting business or representing to the public that the person is a public adjuster of first-party claims for loss or damage to real or personal property of an insured.
3. Directly or indirectly soliciting the business of investigating or adjusting losses, or of advising an insured about first-party claims for loss or damage to real or personal property of the insured.

"Uniform business entity application" means the current version of the NAIC's uniform business entity application for resident and nonresident business entities.

"Uniform individual application" means the current version of the NAIC's uniform individual application for resident and nonresident individuals.

191—55.3(82GA,HF499) License required to operate as public adjuster.

55.3(1) A person shall not operate as or represent that the person is a public adjuster in this state unless the person is licensed by the division in accordance with this chapter.

55.3(2) A person licensed as a public adjuster in accordance with this chapter shall assist only insureds with first-party claims.

55.3(3) Notwithstanding subrule 55.3(1), a license as a public adjuster shall not be required of the following:

a. An attorney-at-law admitted to practice in this state, when acting in the attorney's professional capacity as an attorney;

b. A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

c. A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers and handwriting experts;

d. A licensed health care provider, or an employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

e. A person who settles subrogation claims between insurers.

191—55.4(82GA,HF499) Application for license.

55.4(1) A person applying for a public adjuster license shall make application on a uniform individual application or uniform business entity application available from the division by mail, through the division's Web site (www.iid.state.ia.us), or as otherwise directed by the division.

55.4(2) Each individual resident applying for a public adjuster license shall be required to submit an electronic set of fingerprints with the application, through the division's testing vendor, which shall be used by the division to determine the eligibility of the applicant for a license.

191—55.5(82GA,HF499) Issuance of resident license.

55.5(1) *License of individual.* A resident individual acting as a public adjuster is required to obtain a resident public adjuster license. Application shall be made using the uniform individual application. Before approving the application, the division shall find that the applicant:

a. Either is eligible to designate this state as the individual's home state, or is a nonresident who is not eligible for a license under rule 55.8(82GA,HF499);

b. Has not committed any act that is a ground for denial, suspension or revocation of a license as set forth in rule 55.17(82GA,HF499);

c. Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the division;

d. Is financially responsible to exercise the license and has provided proof of financial responsibility as required in rule 55.10(82GA,HF499);

e. Has paid the fees set forth in rule 55.20(82GA,HF499);

f. Maintains an office in the home state of residence with public access by reasonable appointment or regular business hours;

g. Is at least 18 years of age; and

h. Has successfully passed the public adjuster examination pursuant to rule 55.6(82GA,HF499).

55.5(2) *License of business entity.* A business entity acting as a public adjuster is required to obtain a public adjuster license. Application shall be made using the uniform business entity application. Before approving the application, the division shall find that the business entity has:

a. Paid the fees set forth in rule 55.20(82GA,HF499);

b. Designated a licensed public adjuster responsible for the business entity's compliance with the insurance laws, rules and regulations of this state; and

c. Designated a licensed individual public adjuster responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

55.5(3) *Supplemental documentation.* The division may require the applicant for either type of license to supply any documents reasonably necessary to verify the information contained in the application.

191—55.6(82GA,HF499) Public adjuster examination.

55.6(1) A resident individual applying for a public adjuster license under this chapter shall pass a written examination, unless exempt pursuant to rule 55.7(82GA,HF499). The examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this state. Examinations required by this rule shall be conducted as prescribed by the division.

55.6(2) Each resident individual applying for an examination shall remit a nonrefundable fee as prescribed by the division and set forth in rule 55.20(82GA,HF499).

55.6(3) A resident individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being scheduled for another examination.

55.6(4) The division may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the fee set forth in rule 55.20(82GA,HF499).

191—55.7(82GA,HF499) Exemptions from examination.

55.7(1) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in another state based on a public adjuster examination shall not be required to complete an examination in this state. However, an individual who moves to this state and who was previously licensed as a public adjuster in another state based on a public adjuster examination shall make application within 90 days of establishing legal residence to become a resident licensed public adjuster pursuant to rule 55.5(82GA,HF499). No examination shall be required of that individual to obtain a public adjuster license. This exemption is available only:

a. If the individual is currently licensed in the other state or if the application is received within 12 months of the cancellation of the applicant's previous license; and

b. If the other state issues a certification that the applicant is licensed and in good standing in that state or was licensed and in good standing at the time of cancellation or if the state's producer database records, or records maintained by the NAIC, its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed and in good standing.

55.7(2) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in this state shall not be required to complete an examination. This exemption is only available if the application is received within 12 months of the termination of the applicant's previous license in this state and if, at the time of termination, the applicant was in good standing in this state.

191—55.8(82GA,HF499) Nonresident license reciprocity.

55.8(1) Unless denied licensure pursuant to rule 55.12(82GA,HF499), an individual for whom Iowa is not the individual's home state, but whose home state awards nonresident public adjuster licenses to residents of Iowa on the same basis, must satisfy the following requirements to obtain an Iowa nonresident public adjuster license:

a. Be licensed as a resident public adjuster and in good standing in the individual's home state;

b. Submit a proper request for licensure to the division through the NIPR Gateway; and

c. Pay the appropriate fees required, as set forth in rule 55.20(82GA,HF499).

55.8(2) The division may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

55.8(3) As a condition to continuation of a public adjuster license issued under this rule, the licensed public adjuster shall maintain a resident public adjuster license in the licensed public adjuster's home state. The nonresident public adjuster license issued under this chapter shall terminate and be surrendered immediately to the division if the home state public adjuster license terminates for any reason, unless

the individual has been issued a license as a resident public adjuster in the individual's new home state. The individual shall notify the state or states where nonresident public adjuster licenses are issued as soon as possible, but no later than 30 days after the change to the new state's resident public adjuster license. The licensed public adjuster shall include both the new and the old addresses in the notice. A new state resident public adjuster license is required for the Iowa nonresident public adjuster license to remain valid. The new state resident public adjuster license must have reciprocity with Iowa as set forth in subrule 55.8(1) for the nonresident public adjuster license not to terminate. No fee or license application is required. If the new resident state is actively participating in the producer database, a letter of certification is not required. A nonresident licensed public adjuster who moves to Iowa and wishes to retain the nonresident license must file a change of address with the division within 90 days of the change of legal residence.

55.8(4) If an individual's home state does not license public adjusters or does not award nonresident public adjuster licenses to residents of Iowa on the same basis, the nonresident individual shall follow the procedures for obtaining a license set out in rule 55.5(82GA,HF499).

191—55.9(82GA,HF499) Terms of licensure. Unless denied licensure under this chapter or under 2007 Iowa Acts, House File 499, sections 24 to 29, persons who have met the requirements of this chapter and 2007 Iowa Acts, House File 499, sections 24 to 29, shall be issued a public adjuster license.

55.9(1) Content of license. The license shall contain the public adjuster's name, city and state of business address, license number, the date of issuance, the expiration date, and any other information the division deems necessary. The license number shall be the same as the public adjuster's National Insurance Producer Registry (NIPR) national producer number (NPN). The division will not send a paper license to the public adjuster, but public adjusters may download and print licenses through the division's Web site, www.iid.state.ia.us.

55.9(2) Term of license. A public adjuster license shall remain in effect for a term of two years, unless revoked, terminated or suspended, and may be continually renewed as long as the request for renewal is received, the fee set forth in rule 55.20(82GA,HF499) is paid, and any other requirements for license renewal are met by the renewal due date. The license term shall be as follows:

a. For an individual public adjuster, the two-year-and-one-month period of time beginning on the first day of the public adjuster's birth month and ending on the last day of the public adjuster's birth month in the renewal year.

b. For a business entity public adjuster, the two-year-and-one-month period of time, including the year of application, beginning on the first day of the month of the business entity's formation date and ending on the last day of the month of the business entity's formation date. By arrangement with the division, a business entity may choose a different month for its license term.

55.9(3) Suspension for returned payment. If the division issues or renews a public adjuster license and subsequently determines that payment by check for the license or renewal was returned to the division by a bank without payment, or that the credit card company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the division are paid, at which time the license may be reinstated. The individual may request a hearing within 30 days of receipt of notice by the division that the license was suspended.

55.9(4) Change in name, address or state of residence.

a. Name change. If a licensed public adjuster's name is changed, the licensed public adjuster must file notification with the division within 30 days of the name change. Notification may be filed via electronic mail to producer.licensing@iid.state.ia.us, or through the NIPR Gateway, if available. The notification must include the licensed public adjuster's:

(1) Former name;

(2) License number; and

(3) New name.

b. Address change. If a licensed public adjuster's address is changed, including an E-mail address, the licensed public adjuster must file notification with the division within 30 days of the address change.

Notification may be filed via electronic mail to producer.licensing@iid.state.ia.us, or through the NIPR Gateway, if available. The notification must include the licensed public adjuster's:

(1) Name;

(2) License number;

(3) Previous address; and

(4) New address. A licensed public adjuster may designate a business address instead of a resident address at the option of the licensed public adjuster.

c. Change in state of residence. A nonresident licensed public adjuster who moves from one state to another state or an Iowa resident licensed public adjuster who moves to another state and wishes to retain an Iowa license must comply with subrule 55.8(3).

55.9(5) Reporting of actions.

a. A licensed public adjuster shall report to the division any administrative action taken against the licensed public adjuster in another jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

b. Within 30 days of the initial pretrial hearing date, a licensed public adjuster shall report to the division any criminal prosecution of the licensed public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

c. A licensed public adjuster shall report to the division all college student aid commission or child support recovery unit actions taken under or in connection with Iowa Code chapter 261 or 252J and all court orders entered in such actions.

55.9(6) Failure to notify the division or to file reports required by this rule is a violation of this chapter and will subject licensed public adjusters to penalty pursuant to subrule 55.19(82GA,HF499).

55.9(7) Renewal of license.

a. A person licensed as a public adjuster must apply for renewal of the license prior to the expiration date of the license.

b. Public adjuster licenses may be renewed only through the NIPR Gateway, or as otherwise directed by the division.

c. Failure to renew a license and to pay appropriate fees prior to the expiration date of the license will result in expiration of the license.

d. A resident public adjuster may reinstate an expired license up to 12 months after the license expiration date by submitting a request to the division and by paying a reinstatement fee and license renewal fees, as set forth in rule 55.20(82GA,HF499). A resident public adjuster who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

e. A nonresident public adjuster may reinstate an expired license up to 12 months after the license expiration date by submitting a request to the division through the NIPR Gateway and by paying a reinstatement fee and license renewal fee. A nonresident public adjuster who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

f. A licensed public adjuster that is unable to comply with license renewal procedures due to military service, a long-term medical disability, or some other extenuating circumstance may make a request to the division for a waiver of those procedures.

55.9(8) Division functions.

a. If a licensed public adjuster has provided an E-mail address to the division, the division has the option to send information to the licensed public adjuster through E-mail rather than through United States mail.

b. In order to assist in the performance of the division's duties, the division may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions that the division may deem appropriate, including the collection of fees and data related to licensing.

191—55.10(82GA,HF499) Evidence of financial responsibility.

55.10(1) Prior to the issuance of a license as a public adjuster and for the duration of the license, an applicant shall secure evidence of financial responsibility in a format prescribed by the division through a surety bond. The surety bond shall be executed and issued by an insurer authorized to issue surety bonds in this state, which bond:

a. Shall be in the minimum amount of $20,000;

b. Shall be in favor of this state and shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices in the applicant's capacity as a public adjuster; and

c. Shall not be terminated unless at least 30 days' prior written notice has been filed with the division and submitted to the licensed public adjuster.

55.10(2) The division may request the evidence of financial responsibility at any time the division deems relevant.

55.10(3) A public adjuster shall immediately notify the division if evidence of financial responsibility terminates or becomes impaired. The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

191—55.11(82GA,HF499) Continuing education.

55.11(1) An individual who holds a public adjuster license shall satisfactorily complete a minimum of 24 credits of continuing education, including 2 credits of ethics, reported on a biennial basis in conjunction with the license renewal cycle. "Credit" means 50 minutes of instruction or reading material in an acceptable topic of continuing education.

55.11(2) This rule shall not apply to a licensed public adjuster holding a nonresident public adjuster license who has met the continuing education requirements of the adjuster's home state and whose home state gives credit to residents of this state on the same basis.

55.11(3) Only continuing education courses approved by the division pursuant to 191—Chapter 11, substituting "public adjuster" for "insurance producer," shall be used to satisfy the continuing education requirement of subrule 55.11(1).

191—55.12(82GA,HF499) License denial, nonrenewal or revocation.

55.12(1) The commissioner may place on probation, suspend, revoke or refuse to issue or renew a public adjuster's license or may levy a civil penalty in accordance with Iowa Code section 505.7A or take corrective action pursuant to Iowa Code section 505.8 as amended by 2007 Iowa Acts, House File 499, section 6, or any combination of actions, for any one or more of the following causes:

a. Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

b. Failing to complete continuing education as required by rule 55.11(82GA,HF499);

c. Violating any insurance laws, or violating any regulation, subpoena, or order of the commissioner or of another state's insurance commissioner;

d. Obtaining or attempting to obtain a license through misrepresentation or fraud;

e. Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing adjuster business;

f. Intentionally misrepresenting the terms of an insurance contract;

g. Having been convicted of a felony;

h. Having admitted to or having been found to have committed any insurance unfair trade practice or insurance fraud;

i. Using fraudulent, coercive or dishonest practices; or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

j. Having an insurance license or a public adjuster license, or the equivalent, denied, suspended, or revoked in any other state, province, district or territory;

k. Cheating, including improperly using notes or any other reference material, to complete an examination for any adjuster license;

l. Failing to comply with an administrative or court order imposing a child support or student loan obligation, following procedures of rules 191—10.20(522B) and 191—10.21(522B), replacing the words "producer" with "public adjuster";

m. Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax;

n. Misrepresenting to a claimant that the public adjuster is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster, unless so appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging that specific claimant a fee when the public adjuster is appointed by the insurer and the appointment is accepted by the public adjuster*;*

o. Failing to maintain evidence of financial responsibility as required by rule 55.10(82GA,HF499);

p. For a business entity licensed as a public adjuster, failing to designate only licensed individual public adjusters to exercise the business of the business entity's license;

q. Failing to report to the division any notifications or actions required to be reported pursuant to rule 55.9(82GA,HF499); or

r. Failing to file reports required by this chapter.

55.12(2) In the event that the action by the commissioner is to deny an application for or not to renew a license, the commissioner shall notify the applicant or licensed public adjuster and advise, in writing, the applicant or licensed public adjuster of the reason for the nonrenewal or denial of the applicant's or licensed public adjuster's license. The applicant or licensed public adjuster may request a hearing pursuant to 191—Chapter 3 and Iowa Code chapter 17A.

55.12(3) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensed public adjuster's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the commissioner nor corrective action taken.

55.12(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine pursuant to Iowa Code section 505.7A, or to other corrective action pursuant to Iowa Code section 505.8 as amended by 2007 Iowa Acts, House File 499, section 6.

55.12(5) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and Iowa Code chapters 505 and 522C against any person who is under investigation for or charged with a violation of this chapter and 2007 Iowa Acts, House File 499, sections 24 to 29, even if the person's license has been surrendered or has lapsed by operation of law.

191—55.13(82GA,HF499) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

55.13(1) Definitions and scope.

a. The term "reinstatement" as used in this rule means the reinstatement of a suspended license.

b. The term "reissuance" as used in this rule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter.

c. This rule does not apply to the reinstatement of an expired license.

55.13(2) Any person licensed in Iowa as a public adjuster whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A person licensed as a public adjuster may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding paragraph 55.13(2)*"c"*), revocation, or acceptance of the forfeiture of a license.

55.13(3) All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

55.13(4) An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems desirable, which may include one or more of the types of disciplinary sanctions provided by this chapter and 2007 Iowa Acts, House File 499, sections 24 to 29. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapters 22 and 505.

55.13(5) When a public adjuster's license has been suspended for a period of time which extends beyond the public adjuster's license expiration date, the license will terminate at the license expiration date, and the public adjuster must request reinstatement pursuant to subrule 55.10(2). If suspension for a period of time ends prior to the public adjuster's license expiration date, the division shall reinstate the license at the end of the suspension period. The commissioner is not prohibited from bringing an additional immediate action if the public adjuster has engaged in misconduct during the period of suspension.

55.13(6) A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture shall become effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

55.13(7) A license may be voluntarily forfeited in lieu of compliance with an order of the commissioner or the commissioner's designee with the written consent of the commissioner. The forfeiture shall become effective when and upon such conditions as required by order of the commissioner, which may include one or more of the types of disciplinary sanctions provided by this chapter and 2007 Iowa Acts, House File 499, sections 24 to 29.

191—55.14(82GA,HF499) Contract between public adjuster and insured.

55.14(1) Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

a. Legible full name of the adjuster signing the contract, as specified in division records;

b. Permanent home state business address and telephone number;

c. Public adjuster license number;

d. Title of "Public Adjuster Contract";

e. Insured's full name, street address, insurance company name and policy number, if known or upon notification;

f. Description of the loss and its location, if applicable;

g. Description of services to be provided to the insured;

h. Signatures of the public adjuster and the insured;

i. Date contract was signed by the public adjuster and date the contract was signed by the insured;

j. Attestation language stating that the public adjuster is fully bonded pursuant to state law; and

k. Full salary, fee commission, compensation or other considerations the public adjuster is to receive for services.

55.14(2) The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

a. If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

b. Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract. Any additional expenses shall be approved by the insured.

c. Compensation provisions in a public adjusting contract shall not be redacted in any copy of the contract provided to the division. Such a redaction shall constitute a dishonest practice in violation of paragraph 55.12(1)*"i."*

55.14(3) If the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

a. Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

b. Inform the insured that the loss recovery amount might not be increased by the insurer; and

c. Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

55.14(4) A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any other party who is involved in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, including but not limited to any ownership of, other than as a minority stockholder, or any compensation expected to be received from, any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm that provides estimates for work, or that performs any work, in conjunction with damage caused by the insured loss on which the public adjuster is engaged. The term "firm" shall include any corporation, partnership, association, joint-stock company or person.

55.14(5) A public adjuster contract may not contain any contract term that:

a. Allows the public adjuster's percentage fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company;

b. Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

c. Imposes collection costs or late fees; or

d. Precludes a public adjuster from pursuing civil remedies.

55.14(6) Prior to the signing of the contract, the public adjuster shall provide the insured with a separate disclosure document regarding the claim process as set forth in Appendix I.

55.14(7) The contract shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the division.

55.14(8) The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

55.14(9) The public adjuster shall give the insured written notice of the insured's rights as provided in Iowa Code chapter 555A, and the insured may rescind the contract as provided in Iowa Code chapter 555A. The contract shall not be construed to prevent an insured from pursuing any civil remedy after the three-business-day revocation or cancellation period.

55.14(10) If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within 15 business days following the receipt by the public adjuster of the cancellation notice.

191—55.15(82GA,HF499) Escrow accounts. A public adjuster who receives, accepts or holds, on behalf of an insured, any funds toward the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

191—55.16(82GA,HF499) Record retention.

55.16(1) A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this rule shall include the following:

a. The name of the insured;

b. The date, location and amount of the loss;

c. A copy of the contract between the public adjuster and the insured;

d. The name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;

e. An itemized statement of the insured's recoveries;

f. An itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;

g. A register of all moneys received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees, transfers and disbursements from a trust account and all transactions concerning all interest-bearing accounts;

h. The name of the public adjuster who executed the contract;

i. The name of the attorney representing the insured, if applicable, and the name of the claims representative of the insurance company; and

j. Evidence of financial responsibility in a format prescribed by the insurance division.

55.16(2) Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the division at all times.

55.16(3) Records submitted to the division in accordance with this rule that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the division and shall not be subject to Iowa Code chapter 22.

191—55.17(82GA,HF499) Standards of conduct of public adjuster.

55.17(1) A public adjuster shall serve with objectivity and complete loyalty the interest of the public adjuster's client and shall render to the insured in good faith such information, counsel and service, as within the knowledge, understanding and opinion of the licensed public adjuster, as will best serve the insured's insurance claim needs and interest.

55.17(2) A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

55.17(3) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this chapter or 2007 Iowa Acts, House File 499, sections 24 to 29.

55.17(4) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, unless full written disclosure has been made to the insured as set forth in subrule 55.14(4).

55.17(5) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer as set forth in subrule 55.14(4).

55.17(6) The public adjuster shall abstain from referring or directing the insured to obtain needed repairs or services in connection with a loss from any person, unless disclosed to the insured:

a. With whom the public adjuster has a financial interest; or

b. From whom the public adjuster may receive direct or indirect compensation for the referral.

55.17(7) Licensed public adjusters may not solicit a client for employment between the hours of 8 p.m. and 9 a.m.

55.17(8) Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing, including the source and amount of any such compensation.

55.17(9) A public adjuster shall not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or if the loss or coverage otherwise exceeds the public adjuster's current expertise.

55.17(10) A public adjuster shall not knowingly make any false oral or written material statements regarding any person engaged in the business of insurance to any insured client or potential insured client.

55.17(11) No public adjuster, while so licensed by the division, may represent or act as a company adjuster or independent adjuster in any circumstance.

55.17(12) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

55.17(13) A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

191—55.18(82GA,HF499) Public adjuster fees.

55.18(1) A public adjuster may charge the insured a reasonable fee for public adjuster services.

55.18(2) A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed under this chapter and is not so licensed.

55.18(3) In the event of a catastrophic disaster, there shall be limits on catastrophic fees. No public adjuster shall charge, agree to or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to or more than 10 percent of any insurance settlement or proceeds. No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit, or other thing of value, prior to settlement of a claim, unless the loss is being handled by the public adjuster on a time-plus-expense basis.

191—55.19(82GA,HF499) Penalties. Failure to comply with this chapter or with 2007 Iowa Acts, House File 499, sections 24 to 29, shall subject a person to penalties set forth in 2007 Iowa Acts, House File 499, section 29.

191—55.20(82GA,HF499) Fees.

55.20(1) Fees may be paid by check or credit card.

55.20(2) The fee for obtaining an electronic fingerprint pursuant to subrule 55.4(3) shall be set by the outside vendor under contract with the division and approved by the division.

55.20(3) The fee for issuance or renewal of an individual public adjuster license is $50 for two years.

55.20(4) The fee for issuance or renewal of a business entity public adjuster license is $50 for two years.

55.20(5) The fee for reinstatement of a public adjuster license is $50.

55.20(6) The division may charge a reasonable fee for the compilation and production of public adjuster licensing records.

191—55.21(82GA,HF499) Severability. If any rule or portion of a rule of this chapter, or its applicability to any person or circumstances, is held invalid by a court, the remainder of this chapter, or the applicability or its provisions to other persons, shall not be affected.

These rules are intended to implement 2007 Iowa Acts, House File 499, sections 24 to 29.

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APPENDIX I
DISCLOSURE DOCUMENT
REGARDING THE CLAIM PROCESS

(1) Property insurance policies obligate the insured to present a claim to the insured's insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are as follows:

(a) "Company adjusters" means the insurance adjusters who are employees of insurance companies. They represent the interests of the insurance companies and are paid by the insurance companies. They will not charge the insureds fees.

(b) "Independent adjusters" means the insurance adjusters who are hired on a contract basis by insurance companies to represent the insurance companies' interests in the settlement of claims. They are paid by the insurance companies. They will not charge the insureds fees.

(c) "Public adjusters" means the insurance adjusters who do not work for any insurance companies. They work for insureds to assist in the preparation, presentation and settlement of claims. The insureds hire them by signing contracts agreeing to pay them fees or commissions based on a percentage of the settlements, or other method of compensation.

(2) The insured is not required to hire a public adjuster to help the insured meet the insured's obligations under the policy, but has the right to do so.

(3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney or any other person regarding the settlement of the insured's claim.

(4) The public adjuster is not a representative or employee of the insurer.

(5) The salary, fee, commission or other consideration is the obligation of the insured, not the insurer.

(6) An insured may contact the Iowa Insurance Division with questions about insurance law toll-free from within Iowa at (877)955-1212 or through the Division's Web site at www.iid.state.ia.us.

CHAPTER 56
WORKERS' COMPENSATION GROUP SELF-INSURANCE
[Prior to 10/22/86, Insurance Department[510]]

191—56.1(87,505) General provisions.

56.1(1) Associations which are issued a certificate of approval by the commissioner shall not be deemed to be insurance companies and shall not be subject to the provisions of the insurance laws and regulations contained in Title XX of the Iowa Code except as otherwise provided in this chapter or by statute. Associations are not subject to the premium tax under Iowa Code section 432.1.

56.1(2) The purpose of this chapter is to provide reasonable conditions and restrictions for the approval of self-insurance for workers' compensation liability for associations of employers that have formed an insurance association under Iowa Code section 87.4.

56.1(3) The authority to promulgate these rules is found in Iowa Code section 505.8.

56.1(4) Certificates of relief from insurance shall not exempt a mutual association from Iowa Code chapters 85, 85A, 85B, 86 and 87.

191—56.2(87,505) Definitions.

56.2(1) *"Commissioner"* shall mean the commissioner of the insurance division of Iowa, appointed by the governor pursuant to Iowa Code section 505.2.

56.2(2) *"Division"* shall mean the insurance division of Iowa.

56.2(3) *"Employer"* shall be defined as set forth in Iowa Code section 85.61.

56.2(4) *"Workers' compensation self-insurance association"* or *"association"* means a not-for-profit unincorporated association consisting of five or more employers who are members of the same bona fide business or professional association which has been in existence for not less than five years, and who enter into agreements to pool their liabilities for workers' compensation benefits and employer's liability in this state pursuant to Iowa Code section 87.4.

56.2(5) *"Administrator"* means an individual, partnership or corporation engaged by a workers' compensation self-insurance association's board of trustees to carry out the policies established by the association's board of trustees and to provide day-to-day management of the association.

56.2(6) *"Insolvent"* or *"insolvency"* means the inability of a workers' compensation self-insurance association to pay its outstanding lawful obligations as they mature in the regular course of business, as may be shown either by an excess of its required reserves and other liabilities over its assets or by its not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims owed by it.

56.2(7) *"Net premium"* means premium derived from standard premium adjusted by any advance premium discounts.

56.2(8) *"Service company"* means a person or entity which provides services not provided by the administrator, including but not limited to, (a) claims adjustment, (b) safety engineering, (c) compilation of statistics and the preparation of premium, loss and tax reports, (d) preparation of other required self-insurance reports, (e) development of members' assessments and fees, and (f) administration of a claim fund.

56.2(9) *"Standard premium"* means the premium derived from the manual rates adjusted by experience modification factors but before advance premium discounts.

56.2(10) *"Workers' compensation,"* when used as a modifier of "benefits," "liabilities," or "obligations" means both workers' compensation and employer's liability.

191—56.3(87,505) Requirements for self-insurance.

56.3(1) A proposed workers' compensation self-insurance association shall file with the commissioner its application for a certificate of approval accompanied by a nonrefundable filing fee in the amount of $100. The application shall include the association's name, location of its principal office, date of organization, name and address of each member, and such other information as the commissioner may reasonably require, together with the following:

a. Proof of compliance with the provisions of subrule 56.3(2).

b. A copy of the articles of association, if any.

c. A copy of agreements with the administrator and with any service company.

d. A copy of the bylaws of the proposed association.

e. A copy of the agreement between the association and each member securing the payment of workers' compensation benefits.

f. Designation of the initial board of trustees and administrator.

g. The address in this state where the books and records of the association will be maintained at all times.

h. A pro forma financial statement on a form acceptable to the commissioner showing the financial ability of the association to pay the workers' compensation obligations of its members.

i. Proof of payment to the association by each member of not less than a 25 percent deposit of that member's first year estimated annual net premium on a date prescribed by the commissioner. Such payment shall be considered the deposit premium payment of each member required by subrule 56.17(1), paragraph *"a"* if the proposed association is granted a certificate of approval.

56.3(2) To obtain and to maintain its certificate of approval, a workers' compensation self-insurance association shall comply with the following requirements:

a. A combined net worth of all members of an association of private employers of at least $1 million.

b. Maintain excess insurance of not less than $3 million per occurrence. Associations containing members with a high risk of multiple injury from a single accident may be required to maintain higher limits. The retention shall be the retention generally available to associations with similar exposures and annual premiums.

c. Maintain annual aggregate excess insurance with limits above the aggregate retention of not less than $2 million, with an aggregate retention no greater than the estimated earned normal premium collected in the policy year less all estimated expenses during the year including excess insurance premiums.

d. Provide a security deposit in an amount not less than the association's per occurrence excess insurance retention. The security deposit shall either be in the form of a surety bond on a form prescribed by the commissioner or a financial security endorsement issued by a company authorized under subrule 56.5(1). The commissioner may require a larger security deposit to secure any potential liability of the association not otherwise funded by premium collections or excess insurance.

e. An estimated annual standard premium of at least $250,000 during an association's first year of operation.

f. An indemnity agreement jointly and severally binding the association with private employers and each member thereof to meet the workers' compensation obligations of each member, in a form prescribed by the commission. In an association with public employers, several liability shall not be required.

g. A fidelity bond in the amount of $250,000 for the administrator.

h. A fidelity bond in the amount of $250,000 for the service company. The commissioner may also require the service company providing claim services to furnish a performance bond in a form and amount acceptable to the commissioner.

i. Each association shall have within its own organization ample facilities and competent personnel to service its own program with respect to claims, administration loss prevention, loss control, safety engineering and rehabilitation services for injured employees or members' employees or shall contract with a service company to provide these services.

56.3(3) An association shall notify the commissioner of any change in the information required to be filed under subrule 56.3(1), or in the manner of its compliance with subrule 56.3(2), no later than 30 days after such change.

56.3(4) The commissioner shall evaluate the information provided by the application required to be filed under subrule 56.3(1) to assure that no gaps in funding exist and that funds necessary to pay workers' compensation benefits will be available on a timely basis.

56.3(5) After an initial review, the commissioner may require additional relevant information and additional security.

56.3(6) Within a reasonable time, the commissioner shall issue to the association a certificate of approval upon finding that the applicant association has met all requirements or the commissioner shall issue an order refusing such certificate setting forth reasons for such refusal upon finding that the applicant association does not meet all requirements.

56.3(7) Each workers' compensation self-insurance association shall be deemed to have appointed the commissioner as its attorney to receive service of legal process issued against it in this state. The appointment shall be irrevocable, shall bind any successor in interest, and shall remain in effect as long as there is in this state any obligation or liability of the association for workers' compensation benefits.

191—56.4 Rescinded, effective 4/27/88.

191—56.5(87,505) Excess insurance. No contract or policy of per occurrence or aggregate excess insurance shall be recognized in considering the ability of an applicant to fulfill its financial obligations under the workers' compensation Act, unless such contract or policy complies with the following:

56.5(1) Is issued by a company:

a. Licensed to transact casualty insurance business in this state; or

b. Listed in the most recent NAIC publication "Financial Review of Alien Insurers" (commonly known as the white list); or

c. Listed on the most recent List of Acceptable Non-Admitted Insurers prepared by this department.

56.5(2) Has a term of not less than one year.

56.5(3) No cancellation, termination or alteration of coverage whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation, termination, or alteration has been filed with the commissioner unless an earlier date is approved by the commissioner.

191—56.6(87,505) Rates and reporting of rates.

56.6(1) Every workers' compensation self-insurance association shall adhere to the uniform classification system, uniform experience rating plan, and manual rules filed with the commissioner by an advisory organization designated by the commissioner.

56.6(2) Premium contributions to the association shall be determined by applying the manual rates and rules to the appropriate classification of each member which shall be adjusted by each member's experience credit or debit. Subject to approval by the commissioner, premium contributions may also be reduced by an advance premium discount reflecting the association's expense levels and loss experience.

56.6(3) Notwithstanding subrule 56.6(2), an association may apply to the commissioner for permission to make its own rates. Such rates shall be based on at least five years of the association's experience.

56.6(4) Each association shall have its members audited at least annually by an auditor acceptable to the commissioner to verify proper classifications, experience rating, payroll and rates. For small accounts, members may be audited by use of a mailed questionnaire. A report of the audit shall be filed with the commissioner in a form acceptable to the commissioner.

The audit shall be at the expense of the association.

56.6(5) The rates approved by the commissioner for approved associations prior to the effective date of these rules may remain in effect should the association so choose.

191—56.7(87,505) Special provisions.

56.7(1) If the association fails to pay workers' compensation benefits when due, the commissioner may appoint a party to receive funds from excess insurance or the surety bond, or both, to be disbursed to individual claimants.

56.7(2) The association shall notify the industrial commissioner of all fatalities within ten days of death.

56.7(3) Statutory benefits, and any fees or assessments by the industrial commissioner of Iowa are to be paid by the association for its members.

56.7(4) Loss reserves reported to the commissioner shall not be discounted with respect to investment income. Loss reserves shall only be discounted for remarriage or mortality, or both. If the loss reserves of an association are found to be unreasonably low, the commissioner can require the reserves to be certified annually by an actuary who is a reserve specialist approved by the commissioner.

56.7(5) Assessment provisions.

a. In the event of a deficit in any fiscal year, the deficit shall be immediately made up from any of the following:

(1) Unencumbered surplus from any fiscal year other than the current year;
(2) Moneys not allocated to pay claims;
(3) Retained investment earnings;
(4) Assessment of the membership if ordered;
(5) By such alternative method as the commissioner may order or approve.

b. Liability for assessments will be joint and several. Except public employers will only be jointly liable.

56.7(6) All advertising and solicitation materials must be filed with the commissioner prior to their use.

191—56.8(87,505) Certificate of approval; termination.

56.8(1) The certificate of approval issued by the commissioner to a workers' compensation self-insurance association authorizes the association to provide workers' compensation benefits. The certificate of approval remains in effect until terminated at the request of the association or revoked by the commissioner.

56.8(2) The commissioner shall not grant the request of any association to terminate its certificate of approval unless the association has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the commissioner. Such obligations shall include both known claims and expenses associated therewith and claims incurred but not reported and expenses associated therewith. Subject to the approval of the commissioner, an association may merge with another association engaged in the same or similar type of business only if the resulting association assumes in full all obligations of the merging associations. The commissioner shall hold a hearing on the merger if any party, including a member of either association, so requests.

191—56.9(87,505) Examinations. The commissioner shall examine the affairs, transactions, accounts, records and assets of each association as often as the commissioner deems advisable. The expense of such examinations shall be assessed against the association in the same manner that insurers are assessed for examinations.

191—56.10(87,505) Board of trustees—membership, powers, duties, and prohibitions. Each association shall be operated by a board of trustees which shall consist of not less than five persons whom the board of directors of the parent association may appoint or members of an association may elect for stated terms of office. At least two-thirds of the trustees shall be employees, officers, or directors of members of the association. The association's administrator, service company, or any owner, officer, employee of, or any other person affiliated with, such administrator or service company shall not serve on the board of trustees of the association. All trustees shall be residents of this state or officers of corporations authorized to do business in this state. The board of trustees of each association shall ensure that all claims are paid promptly and take all necessary precautions to safeguard the assets of the association, including all of the following:

56.10(1) The board of trustees shall:

a. Maintain responsibility for all moneys collected or disbursed from the association and segregate all moneys into a claims fund account and an administrative fund account. At least 70 percent of the net premium shall be placed into a designated depository for the sole purpose of paying claims, allocated claims expenses, reinsurance or excess insurance, and special fund contributions. This shall be called the claims fund account. The remaining net premium shall be placed into a designated depository for the payment of taxes, general regulatory fees and assessments, and administrative costs. This shall be called the administrative fund account. The commissioner may approve an administrative fund account of more than 30 percent and a claims fund account of less than 70 percent only if the association shows to the commissioner's satisfaction that more than 30 percent is needed for an effective safety and loss control program, or the association's aggregate excess insurance attaches at less than 70 percent.

b. Maintain minutes of its meetings and make such minutes available to the commissioner.

c. Designate an administrator to carry out the policies established by the board of trustees and to provide day-to-day management of the association, and delineate in the written minutes of its meetings the areas of authority it delegates to the administrator.

d. Retain an independent certified public accountant to prepare the statement of financial condition required by subsection 56.13(2), paragraph *"a."*

56.10(2) The board of trustees shall not:

a. Extend credit to individual members for payment of a premium, except pursuant to payment plans approved by the commissioner.

b. Borrow any moneys from the association or in the name of the association except in the ordinary course of business, without first advising the commissioner of the nature and purpose of the loan and obtaining prior approval from the commissioner.

191—56.11(87,505) Association membership; termination; liability.

56.11(1) An employer joining a workers' compensation self-insurance association after the association has been issued a certificate of approval shall (1) submit an application for membership to the board of trustees or its administrator and (2) enter into the indemnity agreement required by subrule 56.3(2), paragraph *"f."* Membership takes effect no earlier than each member's date of approval. The application for membership and its approval shall be maintained as permanent records of the board of trustees.

56.11(2) Individual members of an association shall be subject to cancellation by the association pursuant to the bylaws of the association. In addition, individual members may elect to terminate their participation in the association. The association shall maintain coverage of each canceled or terminated member for 30 days after notice is given to association members. The association shall also promptly notify the commissioner and the industrial commissioner of the termination or cancellation of a member unless the association is notified sooner by the workers' compensation agency that the canceled or terminated member has procured workers' compensation insurance, has become an approved self-insurer, or has become a member of another association.

56.11(3) The association shall pay all workers' compensation benefits for which each member incurs liability during its period of membership. A member who elects to terminate its membership or is canceled by an association remains jointly and severally liable, for a public member, jointly liable only, for workers' compensation obligations of the association and its members which were incurred during the canceled or terminated member's period of membership.

56.11(4) An association member is not relieved of its workers' compensation liabilities incurred during its period of membership except through payment by the association or the member of required workers' compensation benefits.

56.11(5) The insolvency or bankruptcy of a member does not relieve the association or any other member of liability for the payment of any workers' compensation benefits incurred during the insolvent or bankrupt member's period of membership.

191—56.12(87,505) Requirements of sales agents.

56.12(1) Each person who performs any sales or promotional function for the association, deals with the rates or claims, or makes representations about the available coverage is a "person" within the meaning of Iowa Code chapter 507B and must be of good character and competence.

56.12(2) A licensed insurance agent qualifies under subrule 56.12(1).

56.12(3) The trustees must annually file for approval a list of the names, addresses, and backgrounds of all persons to which subrule 56.12(1) applies. In the case of licensed insurance agents, the name and social security number is sufficient.

191—56.13(87,505) Requirements for continued approval.

56.13(1) A certificate of relief from insurance is continuously valid, subject to the annual filing requirements of 56.13(2), and the annual processing fee of $100. However, the certificate may be revoked under the provisions of rule 56.19(87,505).

56.13(2) By March 1 of each year, each mutual association must submit:

a. A statement of financial condition audited by an independent certified public accountant on or before the last day of the second month following the end of the calendar year. The financial statement shall be on a form prescribed by the commissioner and shall include, but not be limited to, actuarially appropriate reserves for (1) known claims and expenses associated therewith, (2) claims incurred but not reported and expenses associated therewith, (3) unearned premiums, and (4) bad debts, which reserves shall be shown as liabilities. An actuarial opinion regarding reserves for items (1) and (2) above shall be included in the audited financial statement. The actuarial opinion shall be given by a member of the American Academy of Actuaries or other qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners.

The commissioner may prescribe a uniform accounting system for all associations to ensure the accurate and complete reporting of associations' financial information.

Any premium or assessment amount that is not paid within three months of the due date shall be assumed uncollectible for financial statement purposes and in considering the amount of assessments and dividends.

The association shall keep all records and worksheets used to complete the financial statement for at least five years, unless the division permits a shorter time;

b. Proof of excess insurance;

c. Any additional relevant information required by the commissioner;

d. The required renewal fee.

56.13(3) The division reserves the right to require quarterly financial reporting if warranted by the loss experience.

191—56.14(87,505) Misrepresentation prohibited. No person shall make a material misrepresentation or omission of a material fact in connection with the solicitation of a member of an association.

191—56.15(87,505) Investments. Funds not needed for current obligations may be invested by the board of trustees in accordance with Iowa Code section 636.23, subsections 1 to 12.

191—56.16(87,505) Refunds.

56.16(1) Any moneys for a fund year in excess of the amount necessary to fund all obligations for that fund year may be declared to be refundable by the board of trustees not less than 11 months after the end of the fund year.

56.16(2) Each member shall be given a written description of the refund plan at the time of application for membership. A refund plan for moneys in excess of the amount necessary to fund all obligations for a fund year or disbursal of claims fund moneys may be instituted by the association. Such plan must be filed and approved with the commissioner. Payment of a refund based on a member's participation in a previous fund year payable in the following year shall not be contingent on continued membership in the association after that fund year.

56.16(3) A request to the division for authorization to disburse surplus claims moneys shall be made in writing at least 30 days prior to the desired distribution date. The request shall include a current financial statement for the association, a statement by the association that the desired disbursal will not impair the financial condition of the association, a current quarterly status report and a report establishing the adequacy of the reserves in the fiscal year for which the disbursal is requested. The date of payment shall be agreed to by the trustees and the commissioner, but in no event shall such distribution take place less than 11 months after the end of the fiscal year.

56.16(4) If the loss reserves of an association are found to be unreasonably low, the commissioner shall require the reserves to be certified annually by a reserve specialist approved by the commissioner.

191—56.17(87,505) Premium payment; reserves.

56.17(1) Each association shall establish to the satisfaction of the commissioner a premium payment plan which shall include:

a. A deposit premium payment by each member of at least 25 percent of that member's annual premium before the start of the association's fund year. A credit may be available for past unused deposits; and

b. Payment of each member's annual premium in monthly, quarterly or other regular payments.

56.17(2) Each association shall establish and maintain actuarially appropriate loss reserves which shall include reserves for (1) known claims and expenses associated therewith and (2) claims incurred but not reported and expenses associated therewith.

56.17(3) Each association shall establish and maintain bad debt reserves based on the historical experience of the association or other associations.

191—56.18(87,505) Deficits and insolvencies.

56.18(1) If the assets of an association are at any time insufficient to enable the association to discharge its legal liabilities and other obligations and to maintain the reserves required of it under this Act, it shall forthwith make up the deficiency or levy an assessment upon its members for the amount needed to make up the deficiency.

56.18(2) In the event of a deficiency in any fund year, such deficiency shall be made up immediately, by one or more of the methods described in subrule 56.18(1). The commissioner shall be notified prior to any transfer of surplus funds from one fund year to another.

56.18(3) If the association fails to assess its members or to otherwise make up such deficit within 30 days, the commissioner shall order it to do so.

56.18(4) If the association fails to make the required assessment of its members within 30 days after the commissioner orders it to do so, or if the deficiency is not fully made up within 60 days after the date on which such assessment is made, or within such longer period of time as may be specified by the commissioner, the association shall be deemed to be insolvent.

56.18(5) The commissioner shall proceed against an insolvent association in the same manner as the commissioner would proceed against an insolvent domestic insurer in this state as prescribed in Iowa Code sections 515.85 to 515.87 regarding liquidation, conservation, etc. The commissioner shall have the same powers and limitations in such proceedings as are provided under those sections, except as otherwise provided in this chapter.

56.18(6) In the event of the liquidation of an association, the commissioner shall levy an assessment upon its members for such an amount as the commissioner determines to be necessary to discharge all liabilities of the association, including the reasonable cost of liquidation.

191—56.19(87,505) Grounds for nonrenewal or revocation of a certificate of relief from insurance. The following constitute grounds for nonrenewal or revocation of a certificate of relief from insurance:

56.19(1) Failure to comply with any provisions of these rules or of Iowa Code chapter 85, 85A, 85B, 86 or 87;

56.19(2) Failure to comply with any lawful order of the commissioner;

56.19(3) Failure to promptly pay lawful compensation claims;

56.19(4) Committing an unfair or deceptive act or practice;

56.19(5) Deterioration of financial condition adversely affecting the certificate holder's ability to pay expected losses;

56.19(6) The application or any necessary forms that have been filed with the division contain fraudulent information or omissions;

56.19(7) The association or its administrator has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys that belong to a member, an employee of a member, or a person otherwise entitled thereto and that have been entrusted to the association or its administrator in its fiduciary capacities;

56.19(8) Failure to remit the proper amount of premium tax in a timely manner, as required by Iowa Code section 432.1.

191—56.20(87,505) Hearing and appeal. Prior to denying a renewal application or revoking a certificate issued under this chapter, a certificate holder shall be given a hearing and a right to appeal as provided in rule 3.1(17A,502,505) et seq.

191—56.21(87,505) Existing approved self-insurers.

56.21(1) All mutual associations which were given a certificate of relief from insurance or some other approval to group self-insure from the commissioner prior to the effective date of these rules shall bring themselves into full compliance with these rules within 90 days after their effective date or by the filing time set out for renewals, whichever comes later.

56.21(2) An existing association may petition the commissioner for a waiver of a rule or rules. The commissioner may grant such waiver upon showing to the commissioner's satisfaction that the association is solvent and has the ability to pay workers' compensation benefits as required by law.

191—56.22(87,505) Severability clause. If any provision of this chapter, or the application thereof to any person or circumstance, is subsequently held to be invalid, such invalidity shall not affect other provisions or applications of this chapter.

These rules are intended to implement Iowa Code sections 87.4, 87.11, 87.20, 432.1, 505.8 and 509A.14.

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CHAPTER 57
WORKERS' COMPENSATION SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS
[Prior to 10/22/86, Insurance Department[510]]

191—57.1(87,505) General provisions.

57.1(1) The purpose of this chapter is to provide general guidelines for the approval of self-insurance for workers' compensation liability for individual employers.

57.1(2) The authority to promulgate these rules is found in Iowa Code section 505.8.

57.1(3) Certificates of relief from insurance shall not exempt an employer from Iowa Code chapters 85, 85A, 85B, 86 and 87.

57.1(4) The state of Iowa shall be exempt from the requirements of this chapter.

57.1(5) A political subdivision of the state filing for a certificate of relief from insurance under this chapter shall be exempt from the requirements of subrule 57.3(1), but must comply with the other provisions of this chapter.

191—57.2(87,505) Definitions.

57.2(1) *"Commissioner"* shall mean the commissioner of the insurance division of Iowa, appointed by the governor pursuant to Iowa Code section 505.2.

57.2(2) *"Division"* shall mean the insurance division of Iowa.

57.2(3) *"Employer"* shall be defined as set forth in Iowa Code section 85.61.

57.2(4) *"Self-insurer"* shall mean an employer who has been granted relief from the requirement of insurance by the commissioner after having complied with the relevant portions of this chapter but shall not include an employer who is a member of a group of employers under 191—chapter 56.

57.2(5) *"Insolvent"* or *"insolvency"* means the inability of a workers' compensation self-insurer to pay its outstanding lawful obligations as they mature in the regular course of business, as may be shown either by an excess of its liabilities over its assets or by its not having sufficient assets to insure all of its outstanding liabilities after paying all accrued claims owed by it.

57.2(6) *"Parent company"* shall mean a company that owns at least 20 percent of the outstanding stock of another company.

191—57.3(87,505) Requirements for self-insurance. To qualify to receive a certificate of relief from insurance, an employer must satisfy the following requirements:

57.3(1) File with the division an annual surety bond issued by an insurance company licensed to do business in the state of Iowa in an amount determined by applying the formula below, but in no case shall the bond be less than $200,000 or, if an employer cannot obtain a bond, then any other security such as cash or negotiable securities which is agreeable to the commissioner, in an equal amount. Such surety bond shall be in the form prescribed by the commissioner and, in the event of insolvency of the employer, shall be payable to the division to ensure the payment of the employer's workers' compensation liabilities in the same manner as if the division were such employer, subject to the dollar limitation of such surety bond.

The following formula will be used to determine the appropriate amount of security required:

a. Determine the following three ratios:

(1) Current assets: Current liabilities

(2) Capital + retained earning (net of treasury stock) as a percentage of sales (less discounts)

(3) Long term debt: Capital + retained earnings

b. Upon determination of the value for the above ratios, points will be calculated from the following tables:

(1) Current assets to current liabilities

2	:	=	6 Points
1.75	:	=	5 Points
1.6	:	=	4 Points

1.4	:	=	3	Points
1.25	:	=	2	Points
1.1	:	=	1	Point
1	:	=	0	Points

(2) Equity to sales

20%	=	6	Points
17.5%	=	5	Points
13.5%	=	4	Points
10%	=	3	Points
8.5%	=	2	Points
7%	=	1	Point
5%	=	0	Points

(3) Long term debt to equity

1	:	2	=	6	Points
1	:	1.75	=	5	Points
1	:	1.6	=	4	Points
1	:	1.4	=	3	Points
1	:	1.25	=	2	Points
1	:	1.11	=	1	Point
1	:	1	=	0	Points

c. Total the number of points for the three ratios and assign the appropriate percentage:

18		Points	=	0%
16	- 17	Points	=	20%
14	- 15	Points	=	40%
12	- 13	Points	=	60%
9	- 11	Points	=	70%
	Less than 9	Points	=	100%

d. The amount of the required security shall then be calculated as follows:

(1) Determine the three years average of medical payments and compensation paid under the workers' compensation laws (If fiscal year, specify dates _____ through _____.)

Year 1	Year 2	Year 3	Total
$ _____	+ _____	+ _____	= $ _____
Divide the total by 3 =			$ _____
(2) Multiply this average by 2 =			$ _____
(3) Enter the total amount of compensation for fatalities and permanent disabilities, both permanent total and permanent partial for which the employer is presently liable but has not paid, including medical reserves.			$ _____
(4) Add lines 2 and 3			$ _____
(5) Multiply line 4 by the percentage determined in subrule 57.3(1) *"c."* This, when rounded to the nearest thousand, will be the security required.			$ _____

57.3(2) For a private employer, a parental guarantee, completed on forms provided by the division, to cover statutory losses and any loss adjusting expense is required from any parent company.

a. The parental guarantee shall provide for giving the commissioner 60 days' notice for cancellation. Once notice is given, the division reserves the right to require additional security to be obtained prior to the effective date of the cancellation.

b. For a subsidiary that is to be sold, which desires to avoid cancellation of the certificate of relief from insurance, it must file pro forma financial statements representing the condition of the subsidiary before and after sale, sales agreement, financial statement of acquiring company and the parental guarantee of acquiring company.

57.3(3) Each employer shall have within its own organization ample facilities and competent personnel to service its own program with respect to claims, administration, loss prevention, loss control, safety engineering and rehabilitation services for injured employees or shall contract with a service company to provide these services.

191—57.4(87,505) Additional security requirements.

57.4(1) If at any time the commissioner feels additional security is necessary because any one or more of the following factors are present, the commissioner may require such additional security as provided in subrule 57.4(2):

a. Insufficient liquid assets or retained earnings;

b. A deteriorating financial condition, as evidenced by a comparison of current financial statements to recent past financial statements;

c. The workers' compensation loss experience is significantly higher than the average for the industry the company is in;

d. The loss potential within and without the state is higher than what the company can apparently withstand;

e. Any other relevant consideration(s).

57.4(2) When the commissioner determines the conditions of subrule 57.4(1) have been met, any one or more of the following types of additional security may be required, in an amount determined by the commissioner:

a. Additional surety bond;

b. Irrevocable letter of credit;

c. Annual aggregate excess insurance;

d. Specific per occurrence excess insurance; or

e. Trust fund.

(1) If a trust fund is established, the commissioner shall be the trustee. The employer may invest the funds in accordance with Iowa Code section 636.23, subsections 1 through 12. The trust document and the evidence of invested assets are to be kept in the vault of the division or in some other secure place designated by the commissioner.

(2) Interest or dividends, or both, on the trust assets are to accumulate to the trust unless the commissioner deems the trust has sufficient assets, in which case the interest or dividends, or both, are to be delivered to the employer.

(3) The trust fund is to be used to pay losses and loss adjustment expenses if the employer is unable to pay the statutorily required compensation benefits.

191—57.5(87,505) Application for an individual self-insurer.

57.5(1) An applicant for a certificate of relief from insurance shall submit a completed application to the division together with the following:

a. A surety bond or other security, in the amount determined under rule 57.3(87,505);

b. Parental guarantee from the ultimate controlling parent, if applicable;

c. Most recent audited financial statement, such as that included in the shareholders annual report. If such statement is over six months old, also include the latest unaudited financial statement and an affidavit signed by the treasurer of the company stating that there has been no material lessening of net

worth or other adverse changes since the last audited statement, or, if there were, an explanation of such changes. For subsidiaries, this information is to be furnished on the ultimate controlling parent company;

d. Data from the immediate past five years on paid and outstanding Iowa workers' compensation losses subject to self-insurance; and

e. A fee of $100 per application review and $100 per certificate issued, paid in separate checks. If the application is denied, the fee for the issuance of a certificate will be returned to the applicant. The division will either issue one certificate for each parent and each subsidiary or the division will issue one certificate only for the approved parent and all approved subsidiaries, at the applicant's option.

57.5(2) After an initial review, the division may require additional relevant information or additional security, as provided in rule 57.4(87,505).

57.5(3) Within a reasonable time, the division will rule on the application and either issue a certificate of relief from insurance or send a letter denying the application with a specific explanation.

191—57.6 Rescinded, effective 4/27/88.

191—57.7(87,505) Excess insurance. No contract or policy of per occurrence or aggregate excess insurance shall be recognized in considering the ability of an applicant to fulfill its financial obligations under the workers' compensation Act, unless such contract or policy complies with the following:

57.7(1) Is issued by a company:

a. Licensed to transact casualty business in this state; or

b. Listed in the most recent NAIC publication "Financial Review of Alien Insurers" (commonly known as the white list); or

c. Listed on the most recent List of Acceptable Non-Admitted Insurers prepared by this department.

57.7(2) Has a term of not less than one year.

57.7(3) No cancellation, termination or alteration of coverage whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation, termination, or alteration has been filed with the commissioner unless an earlier date is approved by the commissioner.

191—57.8(87,505) Insolvency. If the individual employer becomes insolvent, the commissioner may appoint a party to receive funds on the surety bond or other posted security to be dispersed to individual claimants.

191—57.9(87,505) Renewals.

57.9(1) *Individual employers.*

a. A certificate of relief from insurance is valid for one year, unless sooner revoked under the provisions of rule 57.11(87,505). Such certificate is effective from August 1 to July 31.

b. By June 1 of each year, each individual employer must submit:

(1) A completed application;

(2) A statement of financial condition audited by an independent certified public accountant as of the end of the most recently completed fiscal year. The financial statement shall be on a form prescribed by the commissioner and shall include, but not be limited to, actuarially appropriate reserves for (a) known claims and expenses associated therewith, (b) claims incurred but not reported and expenses associated therewith, (c) unearned premiums and (d) bad debts, which reserves shall be shown as liabilities. An actuarial opinion regarding reserves for items (a) and (b) above shall be included in the audited financial statement. The actuarial opinion shall be given by a member of the American Academy of Actuaries or other qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners;

(3) Any additional relevant information required by the division; and

(4) The required fee.

c. Depending on any change in financial condition, the commissioner may require additional security, as provided in rule 57.4(87,505).

d. The commissioner reserves the right to require financial reports more frequently than once each year if a deterioration in financial security warrants a closer scrutiny of an individual employer.

57.9(2) Rescinded, effective 4/27/88.

191—57.10(87,505) Periodic examination. The commissioner reserves the right to examine an employer as often as it deems necessary. Cost of the examination is to be paid by the employer. Examination shall include but not be limited to adequacy of loss reserves and claims handling practices.

191—57.11(87,505) Grounds for nonrenewal or revocation of a certificate of relief from insurance. The following constitute grounds for nonrenewal or revocation of a certificate of relief from insurance:

57.11(1) Failure to comply with any provisions of these rules or of Iowa Code chapter 85, 85A, 85B, 86 or 87;

57.11(2) Failure to comply with any lawful order of the commissioner;

57.11(3) Failure to promptly pay lawful compensation claims;

57.11(4) Committing an unfair or deceptive act or practice;

57.11(5) Deterioration of financial condition adversely affecting the certificate holder's ability to pay expected losses.

191—57.12(87,505) Hearing and appeal. Prior to denying a renewal application or revoking a certificate issued under this chapter, a certificate holder shall be given a hearing and a right to appeal as provided in rule 191—3.1(17A,502,505) et seq.

191—57.13(87,505) Existing approved self-insurers.

57.13(1) All individual employers which were given a certificate of relief from insurance or some other approval to self-insure from the division prior to the effective date of these rules shall bring themselves into full compliance with these rules within 90 days after their effective date or by the filing time set out for renewals, whichever comes later.

57.13(2) An existing individual self-insurer may petition the commissioner for a waiver of a rule, or rules. The commissioner may grant such waiver upon showing to the commissioner's satisfaction that the employer is solvent and has the ability to pay workers' compensation benefits as required by law.

191—57.14(87,505) Severability clause. If any provision of this chapter, or the application thereof to any person or circumstance, is subsequently held to be invalid, such invalidity shall not affect other provisions or applications of this chapter.

These rules are intended to implement Iowa Code sections 87.11 and 87.20.

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CHAPTER 58
THIRD-PARTY ADMINISTRATORS

191—58.1(510) Purpose. The purpose of this chapter is to administer the provisions of Iowa Code chapter 510 relating to the regulation of third-party administrators.

191—58.2(510) Definitions. The terms defined in Iowa Code section 510.11 shall have the same meaning for the purposes of this chapter.

"Commissioner" means the commissioner of insurance for the state of Iowa.

"Complaint" means a written communication expressing a grievance concerning an administrator.

"Division" means the insurance division of Iowa.

"Person" means an individual, corporation, trust, partnership or association, or any other legal entity.

191—58.3(510) Application. An administrator shall not operate as an administrator in Iowa without an approved application from the division. All administrators wishing to do business in Iowa shall complete an application on a form provided by the division. The application form shall be completed and signed by an officer or authorized representative of the administrator. The completed application form shall be verified and filed at the division with copies in triplicate. The application shall be accompanied by a filing fee of $100 payable to the Iowa division of insurance.

An application will not be deemed to be filed until all information necessary to properly process the application has been received by the commissioner. Upon filing, the division will make its determination concerning the application and will provide notice of the determination to the administrator. If an application is approved, it shall be so stamped and a copy provided to the administrator. The approved application shall serve as the administrator's authorization until the renewal date. Any amendment to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

191—58.4(510) Application by corporation, association or benefit society. An application by a corporation, association or benefit society shall be accompanied by a certified copy of the articles of incorporation or association.

191—58.5(510) Surety bond. All applications shall include a surety bond issued by an insurance company licensed to do business in the state of Iowa in an amount equivalent to 10 percent of the administrator's average daily client account balance during the preceding calendar year. In no case shall the bond be less than $50,000 or more than $1,000,000. If an administrator cannot obtain a bond, then another security including, but not limited to, cash or negotiable securities in an equal amount may be set aside under terms agreeable to the commissioner.

The surety bond shall be in the form prescribed by the commissioner. The bond shall be payable to the commissioner to ensure the financial protection of the administrator's customers, subject to the dollar limitation of the surety bond.

191—58.6(510) Waiver procedure. Administrators applying for a waiver of the registration requirement under Iowa Code section 510.22 shall, in addition to an application, submit a written, detailed and documented statement as to the basis for the requested waiver. The commissioner shall make a determination with regard to the request for waiver within 60 days of receipt of the request by the division.

The commissioner may grant waivers at the commissioner's discretion. However, in order to be considered, the following factors shall be contained in the request for waiver and documented to the commissioner's satisfaction:

1. A certified written statement of the applicant's net worth provided by a certified public accountant. In order to be granted a waiver, the applicant's net worth shall be at least $2 million; and

2. The applicant has been doing business as an administrator as defined in Iowa Code section 510.11 for at least three years; or

3. The administrator generates 10 percent or less of its total revenue from its business as an administrator as defined in Iowa Code section 510.11.

In addition, the division may request any information the commissioner deems relevant in making a determination on a request for waiver. In the case where a waiver is granted, the waiver shall expire at a date which is three years from the date on which the waiver was granted. The commissioner may for good cause revoke a waiver at any time following notice and an opportunity for hearing.

191—58.7(510) Change of information. An administrator shall notify the commissioner in writing of any change in the information required to be filed under these rules including, but not limited to, a change of address or name, no later than 30 days after the change. If notification is not provided, the certificate of registration may be terminated following notice and an opportunity for hearing.

191—58.8(510) Inquiry by commissioner. The commissioner may address any inquiries to an administrator concerning its business. An administrator shall promptly reply in writing to any inquiry made by the commissioner.

An administrator shall keep all complaints on file for a period of five years. Complaint information shall be made available to the division by the administrator at any time upon the commissioner's request.

191—58.9(510) Renewal procedure. An administrator wishing to maintain its certification in Iowa is required to complete a renewal form provided by the division no later than 60 days before the third anniversary of the most recent certificate approval. The renewal form shall meet all the requirements for the original application as described in these rules. The renewal form shall be accompanied by a filing fee of $100 payable to the Iowa division of insurance.

If the renewal form is not filed in the prescribed time, sanctions of rule 58.11(510) may be imposed. Late filings shall be subject to a late filing fee of $500. The division shall provide notice of the renewal or the termination of the certificate of registration.

191—58.10(510) Periodic examination. The commissioner reserves the right to examine an administrator or require the most recent audited financial statements from the administrator and such other interim evidence as the commissioner deems appropriate. Reasonable cost of the examination or audited financial statements is to be paid by the administrator. Examination shall include, but not be limited to: financial condition, premium collection, claims processing and marketing practices.

If any one or more of the following factors are present, the commissioner may require and determine an amount of additional security:

1. Insufficient liquid assets or retained earnings;
2. A deteriorating financial condition, as evidenced through an examination by the commissioner or any other insurance commissioner;
3. Any other relevant consideration(s).

191—58.11(510) Grounds for denial, nonrenewal, suspension or revocation of certificate. The following constitute grounds for denial, nonrenewal, suspension or revocation of an administrator's certificate following notice and an opportunity for hearing:

1. Failure to comply with any provisions of these rules or of Iowa Code section 515.134 and Iowa Code chapter 510;
2. Failure to comply with any lawful order of the commissioner;
3. Committing an unfair or deceptive act or practice as defined in Iowa Code chapter 507B;
4. Deterioration of financial condition adversely affecting the certificate holder's ability to operate as an administrator;
5. Filing an application or any necessary forms with the division which contain fraudulent information or omissions;
6. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person otherwise entitled to it and that have been entrusted to the administrator in its fiduciary capacities;

7. Insufficient explanation, as determined by the commissioner, of the circumstances surrounding evidence that an owner, principal, officer, partner, manager, director, stockholder, trustee, employee of the administrator or the administrator itself:

- Has had an insurance license or an application for an insurance license in any state denied, suspended or revoked;
- Has been the subject of an investigation, fine, penalty, order, withdrawal or informal settlement with any state insurance department;
- Has been the subject of a criminal investigation, summons, arrest, indictment or questioning; or
- Has been charged, tried, convicted of, or pled guilty or no contest to any felony or misdemeanor; or

8. Finding by the commissioner that the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation.

191—58.12(510) Hearing and appeal. Prior to denying an application or a renewal application or suspending or revoking a certificate issued under this chapter, a certificate holder shall be provided with written notice of the commissioner's allegations and provided an opportunity for a hearing and a right to appeal as provided in rule 191—3.1(17A,502, 505) and Iowa Code chapter 17A.

191—58.13(510) Severability clause. If any provision of this chapter, or the application thereof to any person or circumstance, is subsequently held to be invalid, such invalidity shall not affect other provisions or applications of this chapter.

These rules are intended to implement Iowa Code chapter 510.

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CHAPTER 59
PHARMACY BENEFITS MANAGERS

191—59.1(510B) Purpose. The purpose of this chapter is to administer the provisions of Iowa Code Supplement chapter 510B relating to the regulation of pharmacy benefits managers.

191—59.2(510B) Definitions. The terms defined in Iowa Code Supplement section 510B.1 shall have the same meaning for the purposes of this chapter. The definitions contained in 191—Chapter 58, "Third-Party Administrators," and 191—Chapter 78, "Uniform Prescription Drug Information Card," of the Iowa Administrative Code are incorporated by reference. As used in this chapter:

"Clean claim" means a claim which is received by any pharmacy benefits manager for adjudication and which requires no further information, adjustment or alteration by the pharmacist or pharmacies or the insured in order to be processed and paid by the pharmacy benefits manager. A claim is a clean claim if it has no defect or impropriety, including any lack of substantiating documentation, or no particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this chapter. A clean claim includes a resubmitted claim with previously identified deficiencies corrected.

"Complaint" means a written communication expressing a grievance or an inquiry concerning a transaction between a pharmacy benefits manager and a pharmacy or pharmacist.

"Day" means a calendar day, unless otherwise defined or limited.

"Paid" means the day on which the check is mailed or the day on which the electronic payment is processed by the pharmacy benefits manager's bank.

191—59.3(510B) Timely payment of pharmacy claims.

59.3(1) All benefits payable under a pharmacy benefits management plan shall be paid as soon as feasible but within 20 days after receipt of a clean claim when the claim is submitted electronically and shall be paid within 30 days after receipt of a clean claim when the claim is submitted in paper format.

59.3(2) Payments to the pharmacy or pharmacist for clean claims are considered to be overdue if not paid within 20 or 30 days, whichever is applicable. If any clean claim is not timely paid, the pharmacy benefits manager must pay the pharmacy or pharmacist interest at the rate of 10 percent per annum commencing the day after any claim payment or portion thereof was due until the claim is finally settled or adjudicated in full.

59.3(3) Existing contracts between clients and pharmacy benefits managers shall comply with the requirement that clean claims be paid within 20 or 30 days, whichever is applicable, when such contracts are renegotiated on or after January 1, 2009, but no later than December 31, 2009.

191—59.4(510B) Study. On or before December 31, 2009, the commissioner will examine the feasibility of requiring a 15-day payment schedule for electronically submitted claims. The examination shall include economic impact on pharmacy benefits managers, patients, and Iowa pharmacies.

191—59.5(510B) Complaints.

59.5(1) Each pharmacy benefits manager shall develop an internal system to record and report complaints. This system shall include but not be limited to:

a. Complaints from the pharmacy indicating the reason for the complaint and factual documentation to support the complaint;

b. Contact name, address and telephone number of the pharmacy benefits manager;

c. Contact name, address and telephone number of the pharmacy;

d. Prescription number;

e. Prescription reimbursement amount for disputed claim(s);

f. Disputed prescription claim payment date(s);

g. Plan benefits certificate.

59.5(2) A summary of all complaints as outlined in subrule 59.5(1) received by the pharmacy benefits manager shall be submitted to the commissioner on a quarterly basis within 30 days after the calendar quarter has ended.

191—59.6(510B) Auditing practices.

59.6(1) An audit of the pharmacy records by a pharmacy benefits manager shall be conducted in accordance with the following:

a. The pharmacy benefits manager conducting the initial on-site audit must provide the pharmacy written notice at least one week prior to conducting any audit;

b. Any audit which involves clinical or professional judgment must be conducted by or in consultation with a pharmacist;

c. When a pharmacy benefits manager alleges an overpayment has been made to a pharmacy or pharmacist, the pharmacy benefits manager shall provide the pharmacy or pharmacist sufficient documentation to determine the specific claims included in the alleged overpayment;

d. A pharmacy may use the records of a hospital, physician or other authorized practitioner of the healing arts for drugs or medicinal supplies, written or transmitted by any means of communication, for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;

e. Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the pharmacy benefits manager;

f. The period covered by an audit may not exceed two years from the date on which the claim was submitted to or adjudicated by a managed care company, insurance company, third-party payor, or any pharmacy benefits manager that represents such companies, groups, or a department;

g. Unless otherwise consented to by the pharmacy, an audit may not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled during that time;

h. The preliminary audit report must be delivered to the pharmacy within 120 days after conclusion of the audit. A final written audit report shall be received by the pharmacy within six months of the preliminary audit report or final appeal, whichever is later;

i. A pharmacy shall be allowed at least 30 days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit; and

j. The audit criteria set forth in this subrule shall apply only to audits of claims submitted for payment after December 31, 2008.

59.6(2) Notwithstanding any other provision in this rule, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating the recuperation of contractual penalties for audits.

59.6(3) Recuperation of any disputed funds shall occur only after final disposition of the audit, including the appeals process as set forth in subrules 59.6(4) and 59.6(5).

59.6(4) Each pharmacy benefits manager conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the pharmacy benefits manager. If, following the appeal, the pharmacy benefits manager finds that an unfavorable audit report or any portion thereof is unsubstantiated, the pharmacy benefits manager shall dismiss the audit report or said portion without the necessity of any further proceedings.

59.6(5) If, following the final appeal, the pharmacy benefits manager finds that an unfavorable audit report or any portion thereof is found to be substantiated, the pharmacy benefits manager shall already have in place a process for an independent third-party review of the final audit findings. As part of the final appeal process of any final adverse decision, the pharmacy benefits manager shall notify the pharmacy in writing of its right to request an independent third-party review of the final audit findings and the process used to request such a review.

59.6(6) Each pharmacy benefits manager conducting an audit shall, after completion of any review process, provide a copy of the final audit report to the plan sponsor.

59.6(7) This rule shall not apply to any investigative audit which involves fraud, willful misrepresentation, abuse, or any other statutory provision which authorizes investigations relating to but not limited to insurance fraud.

191—59.7(510B) Termination of pharmacy contracts.

59.7(1) A pharmacy or pharmacist shall not be terminated from the network or penalized by a pharmacy benefits manager solely because of filing a complaint, grievance or appeal.

59.7(2) A pharmacy or pharmacist shall not be terminated from the network or penalized by a pharmacy benefits manager due to any disagreement with the decision of the pharmacy benefits manager to deny or limit benefits to covered persons or due to any assistance provided to covered persons by the pharmacy or pharmacist in obtaining reconsideration of the decision of the pharmacy benefits manager.

59.7(3) Termination of contracts between a pharmacy benefits manager and a pharmacy shall include a provision describing notification procedures for contract termination. The contract shall require no less than 60 days' prior written notice by either party that wishes to terminate the contract.

59.7(4) If the pharmacy benefits manager has evidence that the pharmacy or pharmacist has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the pharmacy benefits manager may immediately suspend the pharmacy or pharmacist from further performance under the contract provided written notice of termination is provided to the pharmacy or pharmacist.

59.7(5) Termination of a contract between a pharmacy benefits manager and a pharmacy or pharmacist or termination of a pharmacy or pharmacist from the network of the pharmacy benefits manager shall not release the pharmacy benefits manager from the obligation to make payments due to the pharmacy or pharmacist for services rendered before the contract of the pharmacy or pharmacist was terminated.

59.7(6) Independent third-party review of termination decision. The pharmacy or pharmacist may request an independent third-party review of the final decision to terminate the contract between the pharmacy benefits manager and the pharmacy or pharmacist by filing with the pharmacy benefits manager a written request for an independent third-party review of the decision. This written request must be filed with the pharmacy benefits manager within 30 days of receipt of the final termination decision.

These rules are intended to implement Iowa Code chapters 17A and 514L and Iowa Code Supplement chapter 510B.

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[Editorial change: IAC Supplement 9/24/08]
[Editorial change: IAC Supplement 11/5/08]

*The September 17, 2008, effective date of subrules 59.6(3), 59.6(5) and 59.7(6) was delayed for 70 days by the Administrative Rules Review Committee at its meeting held September 9, 2008. At its meeting held October 14, 2008, the Committee voted to lift the delay, effective October 15, 2008.

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.

191—60.2(515A) Definitions, scope, authority.

60.2(1) The definitions of 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.

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 Web site at www.serff.org.

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.

191—60.4(515A) Rate or manual rule filing.

60.4(1) Every insurer 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 which it proposes to use.

a. An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings on its behalf.

b. 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 for approval by the division.

c. Deviations may be filed at any time during the year and, once approved, need only be refiled to propose changes to the approved deviations 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.

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.

c. A filing must specify whether or not the proposed deviation is to be applied to minimum premiums.

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.

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.

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 which can be given effect without the invalid provisions or application. To this end, all provisions of these rules are declared to be severable.

191—60.7(515A) Effective date. This chapter shall become effective January 1, 2009, and shall apply to acts or practices committed on or after that date.

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]

CHAPTERS 61 to 69
Reserved

MANAGED HEALTH CARE

CHAPTER 70
UTILIZATION REVIEW

191—70.1(505,514F) Purpose. The purpose of this chapter is to:

1. Promote the delivery of appropriate health care in a cost-effective manner.
2. Ensure that any utilization review system used by a third-party payor adheres to reasonable standards for conducting orderly and efficient utilization review processes.
3. Ensure that any utilization review system used by a third-party payor does not result in an unfair discrimination between enrollees of essentially the same class or risk in the benefits payable under a contract for health benefits.
4. Foster greater coordination and cooperation between health care providers and utilization reviewers.
5. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred.

191—70.2(505,514F) Definitions. As used in this chapter, unless the context otherwise requires:

"Commissioner" means the commissioner of insurance.

"Enrollee" means an individual who has contracted for or who participates in health benefits coverage provided through any third-party payor.

"Third-party payor" means any of the following entities:

1. An insurer subject to Iowa Code chapter 509 or 514A.
2. A health service corporation subject to Iowa Code chapter 514.
3. A health maintenance organization subject to Iowa Code chapter 514B.
4. A preferred provider arrangement subject to 191—Chapter 27, Iowa Administrative Code.
5. A multiple employer welfare arrangement.
6. A third-party administrator.
7. A fraternal benefit society.
8. Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

"Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. These standards do not apply to requests by any person or provider for a clarification, guarantee or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically so stated, verification of benefits, preauthorization, and prospective or concurrent utilization review programs shall not be construed in any context as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

191—70.3(505,514F) Application.

70.3(1) A third-party payor which provides health benefits to enrollees residing in the state of Iowa shall not conduct utilization review, either directly or indirectly, by contract with a third party that does not meet the requirements established for accreditation by the Utilization Review Accreditation Commission (URAC) or another national accreditation entity recognized and approved by the commissioner.

70.3(2) On or before March 1 of each year, a third-party payor conducting utilization review shall provide the commissioner with a certification that it is in compliance with this chapter, and shall continuously meet all requirements of the relevant standards in addition to the following information:

a. Name, address, telephone number and normal business hours of the third-party payor and of the utilization review agent if not the same as the third-party payor.

b. Name, address, and telephone number of a person for the commissioner to contact in connection with utilization review compliance.

Any material changes in the information filed in accordance with this rule shall be filed with the commissioner within 30 days of the change.

70.3(3) This chapter does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under:

a. Title XVIII (Medicare) of the federal Social Security Act;

b. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

c. Any other federal employee health benefit plan.

191—70.4(505,514F) Standards. For the purpose of certification and compliance under rule 70.3(505,514F), the most recently available utilization review standards adopted by URAC shall be used.

A copy of the standards and application for accreditation may be obtained from the Utilization Review Accreditation Commission, 1227 25th Street N.W., Suite 610, Washington, D.C. 20037. A copy of the standards shall be readily available and maintained on the premises of any third-party payor conducting utilization review.

191—70.5(505,514F) Retroactive application. A third-party payor shall not impose a retroactive change in procedure that creates an impossibility or impracticability of compliance that would result in a refusal of payment.

191—70.6(505,514F) Variances allowed. Upon application by a third-party payor, the commissioner may approve a variance from the URAC standards for good cause shown, provided such conditions are consistent with the purpose of this chapter. The commissioner shall require the third-party payor to provide reasonable written notice to providers of any approved variance.

70.6(1) Notification of allowed coverage and denials. Notification of the attending physician and treatment facility (as used and defined in the URAC standards) by telephone within one working day is not required provided a documented communication with the physician or the physician's staff and treatment facility is made within one working day of a determination not to certify an admission or extension of a hospital stay.

70.6(2) Individuals who are not licensed health care professionals, but who are otherwise qualified, may perform routine utilization review under the following conditions:

a. They have received full orientation by the utilization review organization relating to administrative practices and policies;

b. They have been fully trained in the application of the medical and/or benefit screening criteria established or endorsed by the utilization review organization;

c. They are trained to refer review requests to licensed health care professionals when the required review exceeds their own expertise, when not addressed in the criteria established or endorsed by the utilization review organization, or when requested by the provider; and

d. They are under the direct supervision of a licensed health care professional.

191—70.7(505,514F) Confidentiality. A third-party payor shall require a contract utilization review agent to adhere to the same standards of patient medical record confidentiality as are directly applicable to the third-party payor.

191—70.8(76GA,ch1202) Utilization review of postdelivery benefits and care. When performing utilization review of inpatient hospital services related to maternity and newborn care, including but not limited to length of postdelivery stay and postdelivery follow-up care, a third-party payor shall use the guidelines adopted under the provisions of 191—81.3(76GA,ch1202) and shall not deselect, require additional documentation, require additional utilization review, terminate services to, reduce payment to, or in any manner provide a disincentive to an attending physician solely on the basis that the attending physician provided or directed the provision of services in compliance with those guidelines. This does not preclude a third-party payor from monitoring a patient's stay or making

reasonable inquiries necessary to assess patient progress in accordance with the guidelines and to coordinate discharge planning or postdischarge care.

191—70.9(505,507B,514F) Enforcement. The remedy for noncompliance with this chapter shall be those remedies authorized by Iowa Code chapters 505 and 507B, including, upon order of the commissioner, payment of outstanding charges, as determined to be reasonable by the commissioner. Upon a finding of a pattern or practice of noncompliance with this chapter, the commissioner may also suspend a person's authority to conduct utilization review.

191—70.10(514F) Credentialing—retrospective payment.

70.10(1) *Purpose.* This rule implements Iowa Code section 514F.6 [2008 Iowa Acts, House File 2555, section 28] which requires the commissioner to adopt rules to provide for the retrospective payment of clean claims for covered services provided by a physician during the credentialing period, once the physician is credentialed.

70.10(2) *Definitions.* For purposes of this rule, the definitions found in Iowa Code section 514F.6 [2008 Iowa Acts, House File 2555, section 28] shall apply. In addition, the following definitions shall apply:

"Application date" means the date on which the health insurer or other entity responsible for the credentialing of physicians on behalf of the health insurer receives the physician's completed application for credentialing.

"Clean claim" means clean claim as defined in Iowa Code section 507B.4A(2)*"b."*

"Health insurer" means the same as a carrier, as defined in Iowa Code section 513B.2(4), that provides health insurance coverage, as defined in Iowa Code section 513B.2(12).

70.10(3) *Retrospective payment of clean claims.* A health insurer shall make retrospective payment for all clean claims submitted by a physician after the credentialing period for covered services provided by the physician during the credentialing period subject to all of the following:

a. The credentialing period shall begin on the application date and end on the date the health insurer or other entity responsible for credentialing physicians on behalf of the health insurer makes a final determination approving the physician's application to be credentialed.

b. The health insurer or other entity responsible for credentialing physicians on behalf of the health insurer shall notify an applicant of its determination regarding a properly completed application for credentialing within 90 days of receipt of an application containing all information required by the health insurer's credentialing form.

c. The physician shall not submit any claims to the health insurer during the credentialing period.

d. A health insurer shall not be required to pay any claims submitted by a physician during the credentialing period.

e. The health insurer's time period for timely submission of claims shall not start until the credentialing period has ended. The health insurer's rules pertaining to timely submission shall not be used to deny payment of any clean claims for medical services provided by a physician during the credentialing period, so long as the physician submits all such claims within the time period required by the health insurer's rules beginning on the date the physician is credentialed.

f. After the physician has been credentialed, the physician shall submit all claims to the health insurer for covered services provided by the physician during the credentialing period.

g. After the physician has been credentialed, a health insurer shall pay all clean claims submitted by the physician for covered services provided by the physician during the credentialing period within the time periods specified in 191—15.32(507B).

70.10(4) *Applicability.*

a. This rule shall not apply to services provided by a physician that are covered by Medicaid, Medicare, TRICARE, or other health care benefit programs subject to federal regulations regarding eligibility and provider payments.

b. Nothing contained in this rule shall require a health insurer or other entity responsible for credentialing physicians on behalf of the health insurer to take any action in violation of the requirements

of the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC).

c. Nothing contained in this rule shall require a health insurer or other entity responsible for credentialing physicians on behalf of the health insurer to credential a physician or to permit a noncredentialed physician to participate in the health insurer's provider network.

70.10(5) *Effective date.* This rule shall become effective on July 22, 2009.

[**ARC 7880B**, IAB 6/17/09, effective 7/22/09]

These rules are intended to implement Iowa Code chapter 507B and sections 505.8, 514C.12, and 514F.2.

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HEALTH BENEFIT PLANS

CHAPTER 71
SMALL GROUP HEALTH BENEFIT PLANS*

191—71.1(513B) Purpose. This chapter is intended to implement the provisions of Iowa Code chapter 513B to provide for the guaranteed issue of all health insurance products in the small group market, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health insurance coverages; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to improve the overall fairness and efficiency of the small group health insurance market and to promote broader spreading of risk in the small employer marketplace. Carriers and ODSs that provide basic and standard health benefit plans, as herein set forth, to small employers are intended to be subject to all provisions of Iowa Code chapter 513B and this chapter of rules.

71.1(1) Health insurance coverage subject to this chapter is available or renewable with respect to all eligible employees or their dependents, at the option of the employer, except for reasons set forth in Iowa Code section 513B.5.

71.1(2) A carrier or organized delivery system subject to this chapter is required to guarantee issue small employer plans except for reasons set forth in Iowa Code chapter 513B.

191—71.2(513B) Definitions. As used in this chapter:

"Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. 1002(1)) that is a multiemployer plan (as defined in 29 U.S.C. 1002(37A)), other than the following:

1. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or
2. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

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

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

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

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

*NOTE: In some instances, the numbering of this chapter does not adhere to the scheme developed for the Iowa Administrative Code.

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

"Creditable coverage" includes short-term limited duration insurance.

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

"Employee" means any individual employed by an employer.

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

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

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

"Health insurance coverage" does not include the following:

1. Flexible spending accounts.
2. Short-term limited duration insurance.
3. Stop loss insurance coverage.

"Health maintenance organization" or *"HMO"* means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514.5.

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

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

"New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in health insurance coverage.

"Organized delivery system" or *"ODS"* means an organized delivery system licensed by the director.

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

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

"Preexisting condition exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an

individual's health status before the individual's first day of coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

"Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

"Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier or ODS that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's or ODS's consent, that is, within 12 months of the date the contract becomes effective.

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

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

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

Other terms shall be defined pursuant to Iowa Code chapter 513B.

191—71.3(513B) Applicability and scope.

71.3(1) *a.* Except as provided herein, this chapter shall apply to any health insurance coverage, whether provided on a group or individual basis, which:

(1) Meets one or more of the conditions set forth in Iowa Code sections 513B.3(1) to 513B.3(3);

(2) Provides coverage to one or more employees of a small employer located in this state without regard to whether the policy or certificate was issued in this state; and

(3) Is in effect on or after July 1, 1991.

b. Except as specifically provided, the provisions of Iowa Code chapter 513B and this chapter shall not apply to health insurance coverages delivered or issued for delivery prior to the effective date of the Act.

71.3(2) *a.* A carrier or ODS that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier or ODS and subject to the provisions of Iowa Code chapter 513B and this chapter with respect to such policies if the small employer contributes, directly or indirectly, to the premiums for the policies and the carrier or ODS is aware, or should have been aware, of such contribution.

b. In the case of a carrier or ODS that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered an eligible small employer as defined in 513B.10 and the small employer carrier subject to 513B.10(1)*"b"*(2) if:

(1) The small employer has at least two employees;

(2) The small employer contributes, directly or indirectly, to the premiums charged by the carrier or ODS; and

(3) The carrier or ODS is aware, or should have been aware, of the contribution by the employer.

71.3(3) Iowa Code chapter 513B and this chapter shall apply to health insurance coverage provided to a small employer or to the employees of a small employer without regard to whether the health insurance coverage is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

71.3(4) An individual health insurance policy shall not be subject to 513B and this chapter solely because the policyholder elects a business expense deduction under Section 162(1) of the Internal Revenue Code, the health insurance coverage is treated as part of a plan or program for purposes of Section 125 of the Internal Revenue Code for which the employee makes all the contributions, the employer provides payroll deduction of health insurance premiums on behalf of an employee if the health insurance coverage covers employees where the employer has applied for group health benefits and has received written notification that the group did not meet the small group carrier's or ODS's minimum participation or contribution standards. The individual health insurance carrier or ODS shall maintain a copy of the employer's notification from the small group carrier for insurance division audit purposes.

71.3(5) *a.* If a small employer is issued health insurance coverage under the terms of 513B, the provisions of 513B and this chapter shall continue to apply to the health insurance coverage in the case that the small employer subsequently employs more than 50 eligible employees. A carrier or ODS providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees but no later than the anniversary date of the employer's health insurance coverage, notify the employer that the protections provided under 513B and this chapter shall cease to apply to the employer if such employer fails to renew its current health insurance coverage or elects to enroll in different health insurance coverage. It is the responsibility of the employer to notify the carrier or ODS of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

b. (1) If health insurance coverage is issued to an employer that is not a small employer as defined, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of Iowa Code chapter 513B shall not apply to the health insurance coverage. The carrier or ODS providing health insurance coverage to such an employer shall not become a small employer carrier or ODS under the terms of Iowa Code chapter 513B solely because the carrier or ODS continues to provide coverage under the health insurance coverage to the employer.

(2) A carrier or ODS providing coverage to an employer described in subparagraph *"b"*(1) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the employer of the options and protections available to the employer under 513B, including the employer's option to purchase a small employer health insurance coverage from any small employer carrier or ODS. It is the responsibility of the employer to notify the carrier of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

71.3(6) *a.* (1) If a small employer has employees in more than one state, Iowa Code chapter 513B and this chapter shall apply to health insurance coverage issued to the small employer if:

1. The majority of eligible employees of such small employer are employed in this state; or
2. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(2) In determining whether the laws of this state or another state apply to health insurance coverage issued to a small employer described in subparagraph (1), the provisions of the paragraph shall be applied as of the date the health insurance coverage was issued to the small employer for the period that the health insurance coverage remains in effect.

b. If health insurance coverage is subject to Iowa Code chapter 513B and this chapter, the provisions of 513B and those set forth herein shall apply to all individuals covered under the health insurance coverage whether they reside in this state or in another state.

71.3(7) A carrier or ODS that is not operating as a small employer carrier or ODS in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued health insurance coverage in another state by that carrier or ODS moves to this state.

191—71.4(513B) Establishment of classes of business.

71.4(1) A small employer carrier or ODS that establishes more than one class of business as defined in Iowa Code section 513B.2 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons as set forth in the definition of "class of business" in Iowa Code section 513B.2;

c. A statement disclosing which, if any, health insurance coverages are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

71.4(2) A carrier or ODS may not directly or indirectly use group size as a criterion for establishing eligibility for health insurance coverage or for a class of business.

191—71.5(513B) Transition for assumptions of business from another carrier.

71.5(1) *a.* A small employer carrier or ODS shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless:

(1) The transaction has been approved by the commissioner of the state of domicile of the assuming carrier or ODS;

(2) The transaction has been approved by the commissioner of the state of domicile of the ceding carrier or ODS; and

(3) The transaction otherwise meets the requirements of this rule and 513B.3(4)*"c."*

b. A carrier or ODS domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier or ODS shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health insurance coverages to be transferred and is consistent with the purposes of Iowa Code chapter 513B and this chapter. The commissioner shall not approve the transaction until at least 30 days after the date of the filing except that, if the ceding carrier or ODS is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

c. (1) The filing required under paragraph 71.5(1)*"b"* shall:

1. Describe the class of business (including any eligibility requirements) of the ceding carrier or ODS from which the health insurance coverage will be ceded;

2. Describe whether the assuming carrier or ODS will maintain the assumed health insurance coverage as a separate class of business (pursuant to 71.5(3)) or will incorporate them into an existing class of business (pursuant to 71.5(4)). If the assumed health insurance coverage will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier or ODS into which the health insurance coverages will be incorporated;

3. Describe whether the health insurance coverages being assumed are currently available for purchase by small employers;

4. Describe the potential effect of the assumption (if any) on the benefits provided by the health insurance coverages to be assumed;

5. Describe the potential effect of the assumption (if any) on the premiums for the health insurance coverages to be assumed;

6. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health insurance coverages to be assumed; and

7. Include any other information required by the commissioner.

(2) A small employer carrier or ODS required to make a filing under 71.5(1)*"b"* shall also make an informational filing with the commissioner of each state in which there are small employer health insurance coverages that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under 71.5(1)*"b"* and shall include at least the information specified in 71.5(1)*"c"*(1) for the small employer health insurance coverages in that state.

d. A small employer carrier or ODS shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless it complies with the following provisions:

(1) The carrier or ODS has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in 71.5(1)*"c"* for the health insurance coverages covering small employers in this state.

(2) If the assumption of a class of business would result in the assuming small employer carrier or ODS being out of compliance with the limitations related to premium rates contained in Iowa Code section 513B.4(1)*"a,"* the assuming carrier or ODS shall make a filing with the commissioner pursuant to Iowa Code section 513B.17 seeking suspension of the application of 513B.4(1)*"a."*

(3) An assuming carrier or ODS seeking suspension of the application of Iowa Code paragraph 513B.4(1)*"a"* shall not complete the assumption of health insurance coverages covering small employers in this state unless the commissioner grants the suspension requested pursuant to 71.5(1)*"d"*(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of 513B.4(1)*"a"* shall, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business).

71.5(2) *a.* Except as provided in paragraph 71.5(1)*"b,"* a small employer carrier or ODS shall not cede or assume the entire insurance obligation or risk for small employer health insurance coverage unless the transaction includes ceding to the assuming carrier or ODS the entire class of business that includes such health insurance coverage.

b. A small employer carrier or ODS may cede less than an entire class of business to an assuming carrier if:

(1) One or more small employers in the class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health insurance coverage to another carrier or ODS. In that instance, the transaction shall include each health insurance coverage in the class of business except those health insurance coverages for which a small employer has rejected the proposed cession; or

(2) After a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

71.5(3) Except as provided in 71.5(4), a small employer carrier or ODS that assumes one or more health insurance coverages from another carrier or ODS shall maintain such health insurance coverages as a separate class of business.

71.5(4) A small employer carrier or ODS that assumes one or more health insurance coverages from another carrier or ODS may exceed the limitation contained in Iowa Code section 513B.2 (relating to the maximum number of classes of business a carrier or ODS may establish) due solely to such assumption for a period of up to 15 months after the date of the assumption, provided that the carrier or ODS complies with the following provisions:

a. Upon assumption of the health insurance coverages, such health insurance coverages shall be maintained as a separate class of business. During the 15-month period following the assumption, each of the assumed small employer health insurance coverages shall be transferred by the assuming small employer carrier or ODS into a single class of business operated by the assuming small employer carrier or ODS. The assuming small employer carrier or ODS shall select the class of business into which the assumed health insurance coverages will be transferred in a manner that results in the least possible change to the coverages and rating method of the assumed health insurance coverages.

b. The transfers authorized in paragraph *"a"* shall occur, with respect to each small employer, on the anniversary date of the small employer's coverage, except that an individual small employer period may be extended beyond the first anniversary date up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business.

c. A small employer carrier or ODS making a transfer pursuant to paragraph *"a"* may alter the benefits of the assumed health insurance coverages to conform to the benefits currently offered by the carrier in the class of business into which the health insurance coverages have been transferred.

d. The premium rate for an assumed small employer health insurance coverage shall not be modified by the assuming small employer carrier or ODS until the health insurance coverage is transferred pursuant to paragraph *"a."* Upon transfer, the assuming small employer carrier or ODS shall calculate a new premium rate for the health insurance coverage from the rate manual established for the class of business into which the health insurance coverage is transferred. In making such calculation, the risk load applied to the health insurance coverage shall be no higher than the risk load applicable to such health insurance coverage prior to the assumption.

e. During the 15-month period provided in this subrule, the transfer of small employer health insurance coverages from the assumed class of business in accordance with this subrule shall not be considered a violation of the first sentence of Iowa Code section 513B.4(4).

71.5(5) An assuming carrier or ODS may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health insurance coverage (or with respect to any health insurance coverage subsequently offered to a small employer covered by such an assumed health insurance coverage) that are more stringent than the requirements applicable to such health insurance coverage prior to the assumption.

71.5(6) The commissioner may approve a longer period of transition upon application of a small employer carrier or ODS. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

71.5(7) Nothing in this rule or in Iowa Code chapter 513B is intended to:

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier or ODS related to the transaction;

b. Authorize a carrier or ODS that is not admitted to transact the business of insurance in this state to offer health insurance coverages in this state; or

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

191—71.6(513B) Restrictions relating to premium rates.

71.6(1) *a.* A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this rule. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

b. (1) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purpose of Iowa Code chapter 513B and this chapter.

(2) A carrier may modify the rating method for a class of business only with prior approval of the commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the commissioner at least 30 days prior to the proposed date of the change. The filing shall contain at least the following information:

1. The reasons the change in rating method is being requested;
2. A complete description of each of the proposed modifications to the rating method;
3. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than 10 percent due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in health insurance coverage);

4. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

5. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Iowa Code section 513B.4.

(3) For the purpose of this rule a change in rating method shall mean:

1. A change in the number of case characteristics used by a small employer carrier or ODS to determine premium rates for health insurance coverages in a class of business;

2. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health insurance coverages in a class of business;

3. A change in the method of allocating expenses among health insurance coverages in a class of business; or

4. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10 percent.

For the purpose of subparagraph (3), paragraph "1" above, a change in a rating factor shall mean the cumulative change, with respect to such factor, considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the carrier shall consider the cumulative effect of all such changes in applying the 10 percent test under paragraph "1." A filing which has not previously been approved, denied, or questioned is deemed approved on or after 30 days from receipt by the division.

71.6(2) *a.* The rate manual developed pursuant to 71.6(1) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

b. A small employer carrier may not use case characteristics other than those specified in 513B.4(2) without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under 71.6(1)*"b."*

c. A small employer carrier or ODS shall use the same case characteristics in establishing premium rates for each health insurance coverage in a class of business and shall apply them in the same manner in establishing premium rates for each health insurance coverage. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

d. The rate manual developed pursuant to 71.6(1) shall clearly illustrate the relationship among the base premium rates charged for each health insurance coverage in the class of business. If the new business premium rate is different than the base premium rate for a health insurance coverage, the rate manual shall illustrate the difference.

e. Differences among base premium rates for health insurance coverages shall be based solely on the reasonable and objective differences in the design and benefits of the health insurance coverages and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage. A small employer carrier or ODS shall apply case characteristics and rate factors within a class of business in a manner that ensures that premium differences among health insurance coverages for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health insurance coverages and are not due to the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage.

f. The rate manual developed pursuant to 71.6(1) shall provide for premium rates to be developed in a two-step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Iowa Code section 513B.4, to reflect the risk characteristics of the group.

g. (1) Except as provided in subparagraph (2), a premium charged to a small employer for a health insurance coverage shall not include a separate application fee, underwriting fee or any other separate fee or charge.

(2) A carrier or ODS may charge a separate fee with respect to a health insurance coverage (but only one fee with respect to such plan) provided the fee is no more than $5 per month per employee and is applied in a uniform manner to each health insurance coverage in a class of business.

h. A small employer carrier or ODS shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses are allocated to other health insurance coverages in the class of business. The rate manual developed pursuant to 71.6(1) shall describe the method of allocating administrative expenses to the health insurance coverages in the class of business for which the manual was developed.

i. Each rate manual developed pursuant to 71.6(1) shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

j. The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the commissioner.

71.6(3) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than 20 percent.

71.6(4) The restrictions related to changes in premium rates in 513B.4(1)*"c"* and 513B.4(1)*"d"* shall be applied as follows:

a. A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

b. (1) If, for any health insurance coverage with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed the change in the base premium rate for the purposes of 513B.4(1)*"c"* and 513B.4(1)*"d."*

(2) If, for any health insurance coverages with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health insurance coverage shall be considered health insurance coverage into which the small employer carrier or ODS is no longer enrolling new small employers for the purposes of 513B.4(1)*"c"* and 513B.4(1)*"d."*

c. If, for any rating period, the change in the new business premium rate for health insurance coverage differs from the change in the new business premium rate for any other health insurance coverage in the same class of business by more than 20 percent, the carrier or ODS shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within 30 days of the beginning of the rating period.

d. A small employer carrier or ODS shall keep on file, for a period of at least six years, the calculations used to determine the change in base premium rates and new business premium rates for each health insurance coverage for each rating period.

71.6(5) *a.* Except as provided in paragraphs *"b"* through *"d,"* a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(2) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period, and
2. Fifteen percent (prorated for periods of less than one year).

b. In the case of health insurance coverage into which a small employer carrier or ODS is no longer enrolling new small employers, a change in a premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

(2) One plus the lesser of:

1. The change in the base rate or

2. The percentage change in the new business premium for the most similar health insurance coverage into which the small employer carrier or ODS is enrolling new small employers, multiplied by

(3) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period and

2. Fifteen percent (prorated for periods of less than one year).

c. In the case of health insurance coverage described in Iowa Code section 513B.4(2), if the current premium rate for the health insurance coverage exceeds the ranges set forth in 513B.4(1), the formulae set forth in paragraphs *"a"* and *"b"* will be applied as if the 15 percent adjustment provided in 71.6(5)*"a"*(2)"2" and 71.6(5)*"b"*(3)"2" were a zero percent adjustment.

d. Notwithstanding the provisions of paragraphs *"a"* and *"b,"* a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in 513B.4(1)*"b."*

71.6(6) *a.* A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the commissioner a request for the waiver of application of the provisions of 513B.4 with respect to such trust.

b. A request made under paragraph *"a"* shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provisions would:

(1) Adversely affect the participants and beneficiaries of the trust; and

(2) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

c. A waiver granted under 513B.4A shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

191—71.7(513B) Requirement to insure entire groups.

71.7(1) *a.* A small employer carrier or ODS that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. The small employer carrier or ODS shall provide the same health insurance coverage to each employee and dependent.

b. Except as provided in Iowa Code section 513B.10(4) (with respect to exclusions for preexisting conditions), the choice among insurance coverages may not be limited, restricted or conditioned upon the risk characteristics of the employees or their dependents.

71.7(2) *a.* Except as provided in this subrule, a small employer carrier or ODS may not issue health insurance coverage to a small employer unless the health insurance coverage covers all eligible employees and all dependents of eligible employees.

b. A small employer carrier or ODS may issue health insurance coverage to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

(1) The excluded individual has coverage under health insurance coverage or other health coverage arrangement, including that set forth in Iowa Code chapter 514E, that provides coverage similar to or exceeding benefits provided under the basic health insurance coverage;

(2) The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for health insurance coverage that is adverse to the small employer;

(3) The excluded individual states in a signed waiver that the individual has had coverage under health insurance coverage or other health arrangement, including that set forth in Iowa Code chapter 514E, within the previous six months and reasonably expects to have coverage within the succeeding six months under health insurance coverage or other health arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

c. A small employer carrier or ODS shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees. The small employer carrier or ODS shall require the small employer to provide

appropriate supporting documentation in the form of a W-2 Summary Wage and Tax Form and federal or state quarterly withholding statements for the current year and the year immediately preceding the year of application for coverage.

(1) A small employer carrier or ODS shall secure a waiver, with respect to each eligible employee and each dependent of an eligible employee, declining an offer of coverage under health insurance coverage provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health insurance coverage. The waiver form shall require that the reason for declining coverage is stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier or ODS for a period of six years.

(2) A small employer carrier or ODS shall obtain, with respect to each individual who submits a waiver under 71.7(2)*"c"*(1), information sufficient to establish that the waiver is permitted under 71.7(2)*"b."*

d. (1) A small employer carrier or ODS shall not issue coverage to a small employer if the carrier is unable to obtain the list required under 71.7(2)*"c,"* a waiver required under 71.7(2*)"c"*(1) or the information required under 71.7(2)*"c"*(2) in circumstances set forth in this subrule.

(2) 1. A small employer carrier or ODS shall not offer coverage to a small employer if the carrier or ODS, or a producer for such carrier or ODS, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

2. A producer shall notify a small employer carrier or ODS, prior to submitting an application for coverage with the carrier or ODS on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

71.7(3) *a.* New entrants to a small employer group shall be offered an opportunity to enroll in the health insurance coverage currently held by such group. A new entrant that does not exercise the opportunity to enroll in the health insurance coverage within the period provided by the small employer carrier or ODS may be treated as a late enrollee by the carrier or ODS, provided that the period provided to enroll in the health insurance coverage extends at least 30 days after the date the new entrant is notified of the opportunity to enroll. If a small employer carrier or ODS has offered more than one health insurance coverage to a small employer group pursuant to 71.7(1)*"b,"* the new entrant shall be offered the same choice of health insurance coverages as the other members of the group.

b. A small employer carrier or ODS shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with Iowa Code section 513B.10(4)), with respect to a new entrant that is longer than 60 days. This subrule does not affect an employer's ability to determine an employee's probationary period of work prior to the commencement of benefits.

c. New entrants to a group shall be accepted for coverage by the small employer carrier or ODS without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents except that a carrier may exclude coverage for preexisting medical conditions consistent with the provisions provided in 513B.10.

d. A small employer carrier or ODS may assess a risk load to the premium rate associated with a new entrant consistent with the requirements of Iowa Code section 513B.4. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

71.7(4) *a.* (1) In the case of an eligible employee (or dependent of an eligible employee) who, prior to July 1, 1993, was excluded from coverage or denied coverage by a small employer carrier or ODS in the process of providing health insurance coverage to an eligible small employer (as defined in Iowa Code section 513B.2(16)), the small employer carrier or ODS shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in health insurance coverage currently held by the small employer.

(2) A small employer carrier or ODS may require an individual who requests enrollment under this subrule to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.

The opportunity to enroll shall meet the following requirements:

b. (1) The opportunity to enroll shall begin October 1, 1993, and extend for a period of at least three months.

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subrule shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with 71.7(3).

(3) The terms of coverage offered to an individual described in subparagraph *"a"*(1) may exclude coverage for preexisting medical conditions if the health insurance coverage currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subrule.

(4) A small employer carrier or ODS shall provide written notice at least 45 days prior to the opportunity to enroll provided in 71.7(4)*"a"*(1) to each small employer insured under health insurance coverage offered by such carrier or ODS. The notice shall clearly describe the rights granted under this subrule to employees and dependents previously excluded or denied coverage and the process for enrollment of such individuals in the employer's health insurance coverage.

191—71.8(513B) Case characteristics.

71.8(1) A small employer carrier may use age, geographic area, family composition, and group size in establishing premium rates, subject to Iowa Code section 513B.4(2).

71.8(2) Additional rating factors are not allowed without the prior approval of the commissioner.

191—71.9(513B) Application to reenter state.

71.9(1) A carrier or ODS prohibited from writing coverage for small employers in this state pursuant to Iowa Code section 513B.5(2) may not resume offering health insurance coverage to small employers in this state until the carrier or ODS has made a petition to the commissioner or director to be reinstated as a small employer carrier or ODS and the petition has been approved by the commissioner or director. In reviewing a petition, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

71.9(2) In the case of a small employer carrier or ODS doing business in only one established geographic service area of the state, if the small employer carrier or ODS elects to nonrenew health insurance coverage under 513B.5, the small employer carrier or ODS shall be prohibited from offering health insurance coverages to small employers in any other geographic area of the state without the prior approval of the commissioner or director. In considering whether to grant approval, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

191—71.10(513B) Creditable coverage. For purposes of this chapter, creditable coverage shall have the same definition as 1997 Iowa Acts, House File 701, section 10.

191—71.11(513B) Rules related to fair marketing.

71.11(1) *a.* A small employer carrier or ODS shall actively market health insurance coverages including one basic and one standard health benefit plan to small employers in this state. A small employer carrier or ODS may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier or ODS has good cause and has received the prior approval of the commissioner or director.

b. In marketing the basic and standard health benefit plans to small employers, a small employer carrier or ODS shall use at least the same sources and methods of distribution that it uses to market other health insurance coverages to small employers.

71.11(2) *a.* A small employer carrier or ODS, in accordance with the provisions of Iowa Code section 513B.10, shall accept every small employer that applies for health insurance coverage from the small employer carrier or ODS and shall accept every eligible individual who applies for enrollment. The offer shall be in writing and shall include at least the following information:

(1) A general description of the benefits contained in the basic and standard health benefit plans and any other health insurance coverage being offered to the small employer, and

(2) Information describing how the small employer may enroll in the plans.

The offer may be provided directly to the small employer or delivered through a producer.

b. (1) A small employer carrier or ODS shall provide a price quote to a small employer (directly or through an authorized producer) within ten working days of receiving a request for a quote and other information as necessary to provide the quote. A small employer carrier or ODS shall notify a small employer (directly or through an authorized producer) of any additional information needed by the small employer carrier or ODS to provide the quote within five working days of receiving a request for a price quote.

(2) A small employer carrier or ODS shall not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than applied for other health insurance coverage offered by the carrier or ODS.

c. Rescinded IAB 7/16/97, effective 7/1/97.

71.11(3) A small employer carrier or ODS shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health insurance coverages in this state. The service shall provide information to callers regarding application for coverage from the carrier or ODS. The information may include the names and telephone numbers of producers located in geographic proximity to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

71.11(4) The small group carrier or ODS shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier or ODS except, if membership in an association or other group is a requirement for accepting a small employer into health insurance coverage, a small employer carrier or ODS may apply such requirement.

71.11(5) A small employer carrier or ODS may not require, as a condition to the offer or sale of health insurance coverage to a small employer, that the small employer purchase or qualify for any other insurance product or service.

71.11(6) *a.* Carriers offering individual and group health insurance coverages in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513B and this chapter. Carriers or ODSs shall elicit the following information from applicants for such plans at the time of application:

(1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(2) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health insurance coverage as part of a plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106 of the United States Internal Revenue Code.

b. If a small employer carrier or ODS fails to comply with paragraph *"a,"* the small employer carrier or ODS shall be deemed on notice regarding any information that could reasonably have been attained if the small employer carrier had complied with paragraph *"a."*

71.11(7) *a.* A small employer carrier or ODS shall annually file the following information with the commissioner related to health insurance coverages issued by the small employer carrier or ODS to small employers in this state:

(1) The number of small employers that were issued health insurance coverages in the previous calendar year (separated as to newly issued plans and renewals);

(2) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to class of business);

(3) The number of small employer health insurance coverages in force in each county (or by ZIP code) of the state as of December 31 of the previous calendar year;

(4) The number of small employer health insurance coverages that were voluntarily not renewed by small employers in the previous calendar year;

(5) The number of small employer health insurance coverages that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and

(6) The number of small employer health insurance coverages that were issued to small employers that were uninsured for at least the three months prior to issue.

b. The information described in paragraph *"a"* shall be filed no later than March 15 of each year.

71.11(8) A small group carrier shall not price the basic and standard benefit plans nor set the commissions in such a way to make the plans unattractive for a producer to market. A small employer carrier shall provide reasonable compensation, as provided in the plan of operation, to a producer, if any, for the sale of a basic or standard health benefit plan.

71.11(9) A small employer carrier shall establish commission payments for the sale of basic and standard health benefit plans within each class of business at no less than 75 percent of the level of commission payments assessed on other small group health products.

191—71.12(513B) Status of carriers as small employer carriers.

71.12(1) Subject to 71.12(2), a carrier or ODS shall not offer health insurance coverages to small employers or continue to provide coverage under health insurance coverages previously issued to small employers in this state unless the carrier or ODS has made a filing with the commissioner or director that the carrier or ODS intends to operate as a small employer carrier or ODS in this state under the terms of this chapter.

71.12(2) *a.* If a carrier or ODS does not intend to operate as a small employer carrier or ODS in this state, the carrier or ODS may continue to provide coverage under health insurance coverages previously issued to small employers in this state only if the carrier or ODS complies with the following provisions:

(1) The carrier or ODS complies with the requirements of Iowa Code chapter 513B (other than sections 513B.11 to 513B.13) with respect to each of the health insurance coverages previously issued to small employers by the carrier or ODS.

(2) The carrier or ODS provides coverage to each new entrant to health insurance coverage previously issued to a small employer by the carrier or ODS. The provisions of Iowa Code chapter 513B (other than sections 513B.11 to 513B.13) and this chapter shall apply to the coverage issued new entrants.

(3) The carrier or ODS complies with the requirements of 513B.17A, and rule 71.13(513B), as they apply to small employers whose coverage has been terminated by the carrier or ODS, and to individuals and small employers whose coverage has been limited or restricted by the carrier or ODS.

b. A carrier or ODS that continues to provide coverage pursuant to this subrule shall not be eligible to participate in the reinsurance program established under Iowa Code section 513B.11.

71.12(3) If a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in 71.12(2)) for a period of five years from the date of this chapter. Upon a written request from such a carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

191—71.13(513B) Restoration of coverage.

71.13(1) *a.* Except as provided in 71.13(1)*"b,"* a small employer carrier or ODS shall, as a condition of continuing to transact business in this state with small employers, offer to provide health insurance coverage as described in 71.13(3) to any small employer carrier or ODS after January 1, 1993, unless the carrier's or ODS's termination is pursuant to Iowa Code section 513B.5.

b. The offer required under 71.13(1)*"a"* shall not be required with respect to health insurance coverage that was not renewed if:

(1) The health insurance coverage was not renewed for reasons permitted in Iowa Code section 513B.5(1), or

(2) The nonrenewal was a result of the small employer voluntarily electing coverage under different health insurance coverage.

71.13(2) The offer made under 71.13(1) shall occur not later than 60 days after July 2, 1993. A small employer shall be given at least 60 days to accept an offer made pursuant to 71.13(1).

71.13(3) A health insurance coverage provided to a terminated small employer pursuant to 71.13(1) shall meet the following conditions:

a. The health insurance coverage shall contain benefits that are identical to the benefits in the health insurance coverage that was terminated or nonrenewed.

b. The health insurance coverage shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health insurance coverage that was terminated or nonrenewed. In applying such exclusions or limitations, the health insurance coverage shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to 71.13(513B).

c. The health insurance coverage shall not be subject to any provisions that restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

d. The health insurance coverage shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier or ODS shall offer coverage to each dependent of such eligible employees.

e. The premium rate for the health insurance coverage shall be no more than the premium rate charged to the small employer on the date the health insurance coverage was terminated or nonrenewed provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health insurance coverage was terminated or nonrenewed and the date that it is restored, the carrier or ODS may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier or ODS has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may be further adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health insurance coverage may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health insurance coverage is restored. Any such increase shall be subject to the provisions of Iowa Code section 513B.4.

f. The health insurance coverage shall not be eligible to be reinsured under the provisions of Iowa Code section 513B.12, except that the carrier or ODS may reinsure new entrants to the health insurance coverage who enroll after the restoration of coverage.

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

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

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

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

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

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

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

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

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

SMALL EMPLOYER PRODUCTS

	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC	STANDARD
Calendar Year Deductibles (S/F)	$500 x 3	$500 x 2		
E.R. Copayment	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	60%	80%
Out-of-pocket per insured/family maximum	$4,800/$14,400	$2,000/$4,000	$4,000/$8,000 (excludes deductibles and copays)	$2,000/$4,000
Annual Maximum				
Lifetime Maximum	$250,000	$1,000,000	$250,000	$1,000,000
Pre-Existing	513B.10(3)	513B.10(3)	513B.10(3)	513B.10(3)
Late Entrant	513B.2(12)	513B.2(12)	513B.2(12)	513B.2(12)
Wellness	100% first $100 60% over $100	100% first $150 80% over $150	100% after $20 copay per visit	100% after $15 copay per visit
Maternity	60% Enrollee or Spouse Only	80% Enrollee or Spouse	60%	80%
PHYSICIAN SERVICES				
Office Visits	60%(1)	80%(2)	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	60%	80%
Inpatient	60%	80%	60%	80%
Outpatient	60%(1)	80%(2)	60%	80%
Vision Screening				
Vision Examinations				
Immunizations	60%(1)	80%(2)	60%	80%
Well Child	60%(1) (Deductible does not apply)	80%(2) (Deductible does not apply)	100% after $20 copay/visit	100% after $15 copay/visit
Pre-Natal/Post-Natal Outpatient Visits	60%(1)	80%(2)	100% after $50 copay/pregnancy	100% after $50 copay/pregnancy
Inpatient	60%	80%	60% of $400/admit	80% $200/admit
Prostheses	60%	80%	60%	80%
DME—including medical supplies	60%	80%	60%	80%
Ambulance-Emergency	60%	80%	60%	80%
Hospice	60%	80%	60%	80%
Home Health and Physician House Calls	60%	80%	60%	80%
ALCOHOLISM/ SUBSTANCE ABUSE				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)
MENTAL HEALTH				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)

	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC	STANDARD
RX	60%	80%	Copayment greater of $15 or 25%	Copayment greater of $10 or 25%
Transplants		80%		80%

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

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

(3)$50,000 lifetime max.

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

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

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service- related medical conditions;
7. For any illness or injury suffered as a result of any act of war or while in the military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;
9. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;
11. Rendered by a provider that is a member of the insured's immediate family;
12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;
13. Incurred after the date of termination of the insured's coverage;
14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;
16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;
17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
18. For custodial care, domiciliary care or rest cures;
19. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;
20. For screening examinations including X-ray examinations made without film;
21. For sterilization or reversal of sterilizations, or both;

22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;
23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;
28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;
29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;
30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;
31. For travel whether or not recommended by a physician;
32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;
33. For maternity care of dependent children except for complications of pregnancy which is covered as any other illness;
34. For services to the extent that those services are covered by Medicare;
35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);
36. For or related to the transplantation of animal or artificial organs or tissues;
37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;
38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;
39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;
40. For the purchase of wigs or cranial prosthesis;
41. For weekend admission charges, except for emergencies and nonscheduled maternity admissions;
42. For orthomolecular therapy including nutrients, vitamins and food supplements;
43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

71.14(9) All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.14.

191—71.15(513B) Methods of counting creditable coverage.

71.15(1) For purposes of reducing any preexisting condition exclusion period, a group health plan, a carrier, or ODS offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in subrule 71.15(2), except that the plan,

carrier, or ODS may use the alternative method under subrule 71.15(3) with respect to any or all of the categories of benefits described under paragraph 71.15(3)*"b."*

71.15(2) Under the standard method, a group health plan, a health insurance carrier, and an ODS offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

a. For purposes of reducing the preexisting condition exclusion period, a group health plan, a health insurance carrier, or ODS offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

b. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

c. Notwithstanding any other provision of paragraph 71.15(2)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health plan, a health insurance carrier, and an ODS offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 71.15(2)*"b."*

71.15(3) Under the alternative method, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in subparagraph 71.15(3)*"b"*(2) and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 71.15(3)*"a."*

a. A plan, carrier, or ODS using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

b. The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(1) Mental health.
(2) Substance abuse treatment.
(3) Prescription drugs.
(4) Dental care.
(5) Vision care.

c. If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

(3) Under the alternative method, the group health plan, carrier, or ODS counts creditable coverage within a category if any level of benefits is provided within the category.

191—71.16(513B) Certificates of creditable coverage.

71.16(1) Group health plans, carriers, and ODSs shall issue certificates of creditable coverage to persons losing coverage. A group health plan, carrier, or ODS required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. Automatically upon the termination of an individual's group coverage;

b. Automatically upon the termination of COBRA coverage;

c. Upon request within 24 months after coverage ends.

71.16(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. The individual requesting the certificate is not entitled to receive a certificate;

b. The individual requests that the certificate be sent to another plan or carrier or ODS;

c. The plan, carrier, or ODS receiving the certificate agrees to accept the information through means other than a written certificate;

d. The plan, carrier, or ODS receiving the certificate receives the certificate within a reasonable amount of time.

71.16(3) Required information. The certificate shall include the following information:

a. The date the certificate is issued;

b. The name of the group plan providing coverage;

c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;

d. The plan administrator's name, address and telephone number;

e. A telephone number to call for further information if different from above;

f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;

g. The date creditable coverage ended or an indication that the coverage is in force.

71.16(4) Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

71.16(5) Dependent coverage transition rule. A group health plan or carrier or ODS that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

71.16(6) Delivering certificates. The certificate shall be given to the individual, plan or carrier or ODS requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

71.16(7) A group health plan, carrier, or ODS shall establish a procedure for individuals to request and receive certificates.

71.16(8) A certificate is not required to be furnished until the group health plan, carrier, or ODS knows or should have known that dependent's coverage terminated.

71.16(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan, carrier, or ODS shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

191—71.17(513B) Notification requirements.

71.17(1) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of:

a. The existence of any preexisting condition exclusions.

b. The length of time to which the exclusions will apply.

c. The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion.

d. The right of the person to demonstrate creditable coverage including:

(1) The right of the person to request a certificate from a prior group health plan, carrier, or ODS;

(2) A statement that the current group health plan, carrier, or ODS will assist in obtaining the certificate;

(3) That the group health plan, carrier, or ODS will use the alternative method of counting creditable coverage; and

(4) Special enrollment rights when an employee declines coverage for the employee or dependents.

71.17(2) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of the modification of a prior creditable coverage decision when the group health plan, carrier, or ODS subsequently determines either no or less creditable coverage existed provided that the group health plan, carrier, or ODS acts according to its initial determination until the final determination is made.

191—71.18(513B) Special enrollments.

71.18(1) A carrier or organized delivery system shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health plan, if an eligible employee requests enrollment or, if the group health plan makes coverage available to dependents, on behalf of dependent who is eligible but not enrolled under the group health plan, during the special enrollment period, which shall be 30 days following an event described in subrules 71.18(2) and 71.18(3) with respect to the individual for whom enrollment is requested. A carrier or organized delivery system may impose enrollment requirements that are otherwise applicable under terms of the group health plan to individuals requesting immediate enrollment.

71.18(2) An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health plan, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health plan, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health plan or otherwise; and

b. When enrollment was declined for the individual:

(1) The individual had coverage other than under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

c. For purposes of this subparagraph 71.18(2)*"b"*(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health plan; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

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

71.18(3) If the eligible employee has previously declined enrollment under the group health plan but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

71.18(4) Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

191—71.19(513B) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier or ODS offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers and ODSs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—71.20(514C) Treatment options.

71.20(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

71.20(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—71.21(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

71.21(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

71.21(2) The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

71.21(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier or ODS without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—71.22(514C) Provider access. A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 513B and 514C and 1999 Iowa Acts, Senate File 276.

191—71.23(513B) Reconstructive surgery.

71.23(1) A carrier or organized delivery system that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

71.23(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

71.23(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

71.23(4) A carrier or organized delivery system shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier or organized delivery system shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

191—71.24(514C) Contraceptive coverage.

71.24(1) A carrier or organized delivery system that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

71.24(2) A carrier or organized delivery system is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

71.24(3) A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

71.24(4) A carrier or organized delivery system shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

71.24(5) If a carrier or organized delivery system does not provide benefits for a routine physical examination, the carrier or organized delivery system is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement 2000 Iowa Acts, Senate File 2126.

191—71.25(513B) Suspension of the small employer health reinsurance program. Upon the recommendation of the board of directors of the Iowa small employer health reinsurance program and the findings of the commissioner that the operation of the Iowa small employer health reinsurance program pursuant to Iowa Code chapter 513B is not currently cost-effective, the commissioner suspends the operation of the program, effective January 30, 2004, until further notice. After the effective date of the suspension, the program may continue its administration with regard to handling claims and refunds related to activities prior to the suspension as well as other administrative matters.

This rule is intended to implement Iowa Code section 513B.13(14).

191—71.26(513B) Uniform health insurance application form.

71.26(1) Small employer carriers shall use the small employer uniform health insurance application form as the only acceptable form when small employers apply for new health insurance coverage from small employer carriers. Small employer carriers shall implement procedures and policies necessary to use the small employer uniform health insurance application form.

71.26(2) Small employer carriers shall treat and accept a copy of the uniform health insurance application form as an original.

71.26(3) Use of the uniform health insurance application form shall not be required:

a. Upon renewal of an existing small employer group policy, or

b. When adding or removing employees or dependents under an existing small employer group policy.

71.26(4) Form and content of uniform health insurance application.

a. The uniform health insurance application form following this chapter contains the standardized data elements that must be included in the uniform health insurance application to ensure consistent usage by all small employer carriers when small employers apply for new health insurance coverage.

b. The standardized data elements shall not preclude a small employer carrier from utilizing electronic methods or other technologies to accommodate the uniform health insurance application form.

71.26(5) Small employer carriers may preprint the name of the small employer carrier on the uniform health insurance application form provided that the form contains at least three additional spaces to insert the names of small employer carriers to which the uniform health insurance application may be sent.

71.26(6) The information contained in each uniform health insurance application shall be considered current by the small employer carrier for a minimum of 60 days from receipt by the small employer carrier of the earliest signed and completed uniform health insurance application form. For the period of time that the information contained in the uniform health insurance application is considered current, small employer carriers shall not require an employee of a small employer to complete a new application form or any document, addendum or certification representing that the information contained in the completed uniform health insurance application is current.

71.26(7) A small employer carrier may accept and utilize information provided by an employee of a small employer subsequent to the date the employee signed the completed application if the employee is providing the small employer carrier with additional or modified information.

71.26(8) A small employer carrier may require employees of a small employer to complete and submit new uniform health insurance applications if either of the following occurs:

a. The authorization signed by the employees does not include the name of the small employer carrier from which the small employer is requesting an underwritten premium amount and coverage; or

b. The completed uniform health insurance applications are received by the small employer carrier after 60 days of completion of the earliest signed and completed uniform health insurance application.

71.26(9) A producer shall forward, within five business days from receipt of the applications, copies of the uniform health insurance applications to all small employer carriers identified in the uniform health insurance application authorization to receive the applications, or to an authorized representative of each small employer carrier, without requiring that a fee be paid for the photocopying or delivery of the copies of completed uniform health insurance applications. The producer may withhold distribution to a small employer carrier, or the carrier's authorized representative, at the written request of the small employer.

71.26(10) A copy of the completed uniform application, which may be in electronic or other reproduced forms, shall be maintained by the producer that submitted the application and by the small employer carrier that issued the policy.

71.26(11) Small employer carriers shall state the premium to the small employer within ten business days of receipt of all pertinent information required for a small employer carrier's underwriting of the small employer's application for group health insurance, including completed uniform health insurance applications.

71.26(12) Small employer carriers shall make a reasonable effort to promptly obtain information that a carrier determines is necessary to make an underwriting decision.

This rule is intended to implement Iowa Code Supplement section 513B.18.

Iowa Uniform Group Health Application

Agent No.

Employer Data

Employer _____ Group Number _____ Phone _____

Street Address _____ City _____ State _____ Zip _____ Fax _____

Employee Data

Employee Name _____ Soc Sec Disabled? Y N Medicare Enrolled? Y N Sex: M F

Home Address _____ City _____ State _____ Zip _____

Work Phone # _____ Home Phone # _____ Email _____

DOB _____ Height _____ Weight _____ Social Security # _____ Job Title _____ Date of Hire _____

Primary Care Physician _____

Average Hours Worked per Week _____ Salary/Wage $ _____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ COBRA

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Common Law Marriage (Notarized Affidavit Required)

Coverage Selected

Please indicate which eligible coverage(s) you are choosing:	☐ Medical:	☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren) ☐ HMO ☐ PPO ☐ POS ☐ HDHP ☐ Other, define: _____
	☐ Dental:	☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)
	☐ Life:	☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)
	☐ Vision:	☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)
	☐ Disability:	☐ Employee/Short Term ☐ Employee/Long Term

Waiver of Coverage

I decline coverage for:		**Declining coverage due to existence of other coverage:**		
☐ Medical	☐ Dental	☐ Spouse's Employer's Plan	☐ Individual Plan	☐ Medicaid
☐ Life	☐ Vision	☐ Covered by Medicare	☐ VA Eligibility	☐ Tri-Care
☐ Disability		☐ COBRA from prior employer	☐ Other, Explain: _____	
		☐ I (we) have no other coverage at this time.		

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.

Dependent Data

Name (First, MI, Last)	Sex	Height	Weight	Birthdate	Social Security Number	Primary Care Physician	Full-time student?	Medicare enrolled?	Soc. Sec. enrolled?
Spouse	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Name _____

Other Coverage

<table>
<tr><td colspan="3">Medicare Coverage: Name _____ ID# _____
Effective Date (Part A) _____ (Part B) _____ (Part D) _____

Concurrent Coverage: Will you, your spouse or your dependents keep other coverage in addition to this coverage? (Check all that apply.)
□ None □ Medical □ Dental □ Life □ Vision □ Disability</td><td colspan="3">Previous Coverage:
Within the last 18 months, did you have health insurance coverage?
□ Yes □ No
If Yes, please complete the following:</td></tr>
<tr><td colspan="3">Name of covered person(s)</td><td colspan="3">Name of covered person(s)</td></tr>
<tr><td colspan="3">Employer (if applicable)</td><td colspan="3">Employer (if applicable)</td></tr>
<tr><td colspan="3">Insurance Company/HMO Name and address</td><td colspan="3">Insurance Company Name/Address</td></tr>
<tr><td>Policy No.</td><td>□ Employee
□ Employee/Spouse
□ Employee/Children
□ Employee/Spouse/Children</td><td>Effective Date

End Date</td><td>Policy No.</td><td>□ Employee
□ Employee/Spouse
□ Employee/Children
□ Employee/Spouse/Children</td><td>Effective Date

End Date</td></tr>
<tr><td colspan="6">Reason for Enrollment/Change:
Name of Affected Party _____ Date of Event _____
□ New Hire □ Late Enrollee □ Special Enrollee □ Loss of Coverage □ Marriage □ Birth/Adoption □ Death □ Divorce
□ Employment Termination □ COBRA □ Cancel Coverage (reason) _____
□ Other: _____</td></tr>
</table>

Designated Beneficiaries

<table>
<tr><td colspan="4">Group Term Life and/or Voluntary Term Life Beneficiary Designation
(NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below).
All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.</td></tr>
<tr><td colspan="4">Primary Beneficiaries:</td></tr>
<tr><td>Name and Address</td><td>Percentage</td><td>Relationship</td><td>Social Security #</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Contingent Beneficiaries:</td></tr>
<tr><td>Name and Address</td><td>Percentage</td><td>Relationship</td><td>Social Security #</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.</td></tr>
<tr><td colspan="4">If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to the Plan.</td></tr>
<tr><td colspan="4">If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.</td></tr>
</table>

Employee Name _____

Health Information Questions
Please answer each question fully and accurately.
Incomplete answers could delay the processing of your requested coverage.

SECTION 1

Please provide the health history of you and any person named in this application who has been diagnosed or treated in the last **10 years** by placing an "X" in the following boxes. **Please further explain your selections in SECTION 3's Health Statement Table.**

☐ 1. AIDS/HIV
☐ 2. Allergy/Asthma
☐ 3. Arthritis
☐ 4. Bladder/Urinary Disorder
☐ 5. Blood, Bleeding, or Clotting Disorder
☐ 6. Bone/Joint/Muscular Disorder
☐ 7. Cancer
☐ 8. Cyst
☐ 9. Current Pregnancy: due date _____
☐ 10. Diabetes
☐ 11. Digestive/Intestinal Disorder
☐ 12. Drug or Alcohol Abuse
☐ 13. Eating Disorder
☐ 14. Endocrine/Pancreatic Disorder
☐ 15. Eye, Ear, Nose or Throat Disorder (excluding glasses)
☐ 16. Heart/Circulatory Disorder
☐ 17. High Blood Pressure
☐ 18. High Cholesterol
☐ 19. Infertility
☐ 20. Kidney Disorder (Dialysis or failure)
☐ 21. Liver (Cirrhosis, Hepatitis B, C, D or E)
☐ 22. Mental or Nervous Disorder
☐ 23. Migraine Headaches
☐ 24. Neck, Back, or Spine Disorder
☐ 25. Organ transplant
☐ 26. Respiratory/Lung Disorder
☐ 27. Skin Disorder
☐ 28. Stroke/Nervous System/Brain Disorder
☐ 29. Tumor
☐ 30. Tobacco Product Use
☐ 31. Vascular (blood vessel) Disorder

SECTION 2

Please answer yes or no to the following questions. **Please further explain your "Yes" selections in SECTION 3's Health Statement Table.**

☐ Yes ☐ No 32. Have you or any person named in this application received inpatient or outpatient services in the last three (3) years (excluding routine tests, physicals or inoculations)?

☐ Yes ☐ No 33. Do you or any person named in this application have tests, treatments, hospitalization or surgery planned or recommended in the future?

☐ Yes ☐ No 34. Do you or any person named in this application take any medicine, prescriptions drugs, or require shots/injections?

☐ Yes ☐ No 35. Do you or any person named in this application have any other medical conditions which have not yet been previously mentioned?

SECTION 3 Health Statement Table

For any of the "X" or "Yes" responses provided in SECTIONS 1 and 2 above, please provide full details in the following table per Question Number (Q#). If you need additional space, please attach another sheet. (An additional sheet must include your signature and the date on it as verification that the information is yours.)

Q#	*Person Name*	*Condition*	*Date Diagnosed*	*Date Last Treated*	*Type of Treatment/Names of Medication (e.g., oral, injectable, infusion, inhaled, or transdermal)*	*Is Medication Ongoing?*	*Is Treatment Ongoing?*

Employee Name _____

Authorization and Certification

I understand and agree with the following statements with regard to my application for coverage through an insurance Carrier:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.
- I understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier. I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to the life or disability carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", including but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including but not limited to, all health & mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS related complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs, and tobacco, and the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent that the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of all information received and it will not be released to any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers, and their legal representatives to receive, use, and disclose my, my spouse and my dependent child(ren)'s Protected Health Information for the purpose of insurance coverage. I authorize the Carriers to disclose my, my spouse and my dependent child(ren)'s Protected Health Information between themselves, to reinsuring companies, and to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage: *(Either you or your broker must list all Carriers that are to receive this application for insurance.)*

Carrier_____ Carrier_____ Carrier_____

Carrier_____ Carrier_____ Carrier_____

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Carrier.

Print Name _____

Your signature X _____ Date signed _____

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CHAPTER 72
LONG-TERM CARE ASSET PRESERVATION PROGRAM

191—72.1(249G) Purpose. The purpose of this chapter is to establish minimum standards for long-term care insurance policies and certificates to qualify for participation in the Iowa long-term care asset preservation program; establish documentation and reporting requirements for issuers of policies or certificates to qualify under the Iowa long-term care asset preservation program; provide full disclosures in the sale of long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program; and facilitate public understanding regarding long-term care insurance and long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program.

191—72.2(249G) Applicability and scope. The requirements of this chapter apply to any long-term care insurance policy or certificate authorized for sale by the division of insurance as qualifying under the Iowa long-term care asset preservation program under Iowa Code chapter 249G.

191—72.3(249G) Definitions.

"Asset disregard" means a $1 increase in the amount of assets an individual who purchases a certified long-term care policy may retain, upon qualification for Medicaid, for each $1 of benefit paid out under the individual's certified long-term care policy for Medicaid-eligible long-term care services in determining eligibility for the Medicaid program.

"Asset protection" means the right extended by 441 IAC 75.5(5) to beneficiaries of certified long-term care insurance policies and certificates to an asset disregard under the Iowa long-term care asset preservation program.

"Authorized designee" means any person designated in writing to the insurance company by the policyholder or certificate holder of a certified long-term care policy or certificate for purposes of notification under paragraph 72.7(1)*"h."*

"Average daily private pay rate" means the average statewide cost of nursing facility services to a private pay resident as determined by the department of human services in 441 IAC 75.23(3). The average statewide private pay rate is set annually on July 1 for one year by the Iowa department of human services.

"Case management" includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

"Case management agency" means an agency or other entity approved by the Iowa department of human services as meeting Medicaid case management standards.

"Certificate" means any certificate delivered or issued for delivery in this state under a group long-term care policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Certificate holder" means an owner of a certified long-term care insurance certificate or the beneficiary of a certified long-term care certificate.

"Certified long-term care insurance policy or certificate" means any long-term care insurance policy or certificate certified for sale to Iowa residents by the division of insurance as meeting standards promulgated under rules 191—72.6(249G) and 191—72.7(249G).

"Cognitive impairment" means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

1. Short-term or long-term memory.
2. Orientation as to person, place, and time.

3. Deductive or abstract reasoning.

Cognitive impairment must result in an individual's requiring 24-hour-a-day supervision or direct assistance to maintain the individual's safety.

"Complex, yet stable medical condition" means that the individual requires 24-hour-a-day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

"Deficiency in activity of daily living" means that the individual cannot perform one or more of the following six activities of daily living without direct assistance:

1. Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.
2. Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
3. Toileting, meaning getting on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.
4. Transferring, meaning moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.
5. Continence, meaning the ability to control bowel and bladder as well as use ostomy or catheter receptacles and apply diapers and disposable barrier pads.
6. Eating, meaning reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

"Department of human services" means the Iowa division of medical services.

"Direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others.

"Formal long-term care services" means long-term care service for which the provider is paid.

"Home health care services" means:

1. Part-time or intermittent skilled nursing services by licensed nursing personnel provided by a home health agency or by a registered nurse or a licensed vocational nurse, when a case management provider agency has determined that no home health agency exists in the area;
2. Home health aide services provided by a home health agency;
3. Physical therapy, occupational therapy, or speech therapy and audiology services provided by a home health agency; and
4. Medical social services by a social worker or social work assistant provided by a home health agency.

"Homemaker services incidental to personal care" means the policyholder or certificate holder is eligible to receive homemaker services if personal care is being received. Homemaker services incidental to personal care are limited to the following:

1. Domestic or cleaning services;
2. Laundry services;
3. Reasonable food shopping and errands;
4. Meal preparation and cleanup;
5. Transportation assistance to and from medical appointments; and
6. Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

A certified long-term care insurance policy or certificate shall not, if it provides homemaker services incidental to personal care, limit or exclude benefits by requiring that the provision of such services be at

a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers.

"Informal long-term care services" means long-term care services for which the provider is not paid.

"Insured event" means the insured is eligible to receive insurance benefits and to have these benefits qualify for an asset disregard if any one of the following criteria is met:

1. The insured has at least two deficiencies in activities of daily living (ADLs) (to qualify for home-and community-based services including, but not limited to, home health care, adult day health/social care, personal care, homemaker services incidental to personal care, respite care and residential care facility) or three deficiencies in activities of daily living (ADLs) (to qualify for nursing facility care); or
2. The insured has a cognitive impairment; or
3. The insured has a complex, yet stable medical condition.

"Integrated benefits" means the benefits contained in the policy or certificate can be used interchangeably among the various covered home- or community-based or nursing facility benefits, and there is no limit on the use of any specific covered benefit, except for monthly limits that may be set for home-and community-based care benefits and per diem limits that may be set on nursing facility services.

"Issuer" means:

1. Insurance companies;
2. Fraternal benefit societies;
3. Prepaid health care delivery plans;
4. Health care service plans;
5. Health maintenance organizations; and
6. Any other entity delivering or issuing for delivery in this state, long-term care policies or certificates.

"Long-term care asset preservation program" means the program authorized in Iowa Code chapter 249G.

"Medicaid-eligible long-term care services" include:

1. Long-term care services available under Iowa's state Medicaid plan, including care in a licensed nursing facility and home health nursing and home health aide services provided by a home health agency.
2. Long-term care services covered under the Medicaid home- and community-based services waiver for the aged and disabled, as defined in paragraph 72.7(1)*"d."*

"Medicaid waiver" refers to the home- and community-based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Iowa to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Iowa's Medicaid waiver services include:

1. Case management;
2. Homemaker;
3. Respite care;
4. Attendant care;
5. Adult day care; and
6. Other services which, independent of the preceding home- and community-based services, are essential to prevent institutionalization.

"Personal care services" means:

1. Ambulation assistance, including help in walking or moving around (e.g., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.
2. Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching

head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

3. Dressing includes putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

4. Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy or catheter receptacles and urinals, application of diapers and disposable barrier pads.

5. Reposition, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

6. Feeding and hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate; cleaning face and hands as necessary following meal.

7. Assistance with self-administration of medications.

8. A certified long-term care insurance policy or certificate shall not, if it provides personal care services, limit or exclude benefits by requiring that the provision of personal care be at a level of certification or licensure greater than that required by the eligible service, or by limiting benefits to services provided by Medicare-certified agencies or providers.

"Plan of care" means a written individualized plan of services approved by a case management provider agency which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual and the cost, if any, of any formal long-term care services prescribed. Changes in the plan of care must be documented to show that such alterations are required by changes in the client's medical situation, functional or cognitive abilities, behavioral abilities or the availability of social supports.

"Preadmission screening program" means the program which requires that each person seeking admission to a nursing facility must be screened and approved for admission by the Iowa Foundation of Medical Care in accordance with 441 IAC 81.3(249A).

"Qualified insured" means the following:

1. An individual who by reason of age is eligible for parts "A" and "B" of the Medicare program (42 U.S.C. 1395 et seq.) who is either:

- The beneficiary of a certified long-term care policy or certificate approved by the division of insurance; or
- Enrolled in a prepaid health care delivery plan that provides long-term care services and qualifies under this rule; or

2. An individual who is eligible for an asset disregard under a certified long-term care policy or certificate. An individual does not have to be a qualified insured to purchase a certified long-term care policy or certificate.

"Quarterly/annually" refers to periods aligning with the state fiscal year of July 1 to June 30.

"Service summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

1. The specific certified policy or certificate.
2. The total benefits paid for services to date.
3. The amount of benefits qualifying for asset protection.

191—72.4(249G) Qualification of long-term care insurance policies and certificates. No long-term care insurance policy or certificate shall qualify for participation in the Iowa long-term care asset preservation program unless the long-term care insurance policy or certificate complies with this

chapter. Long-term care insurance policies and certificates in force on July 1, 1994, may, with the signed acceptance of the policyholder or certificate holder, be amended to meet the requirements for qualification.

191—72.5(249G) Standards for marketing. No long-term care insurance policy or certificate which does not meet the requirements of this chapter and has not been approved by the division of insurance as a certified long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a certified long-term care insurance policy or certificate. Each issuer seeking to qualify a long-term care policy or certificate for participation in the Iowa long-term care asset preservation program must do the following:

72.5(1) Provide the consumer, prior to presentation of an application for long-term care insurance, information regarding the availability of consumer information and public education provided by the Senior Health Insurance Information Program using the form developed by the division.

72.5(2) Use applications to be signed by the applicant which indicate, as described as follows, that the applicant:

a. Received a complete description of the Iowa long-term care asset preservation program in a format prescribed by the commissioner, including an explanation of asset protection provided by the program and how it is achieved and the insurance division's Senior Health Insurance Information Program consumer information telephone number.

b. Received a description of the issuer's certified long-term care policy or certificate benefit option meeting the requirements of subrule 72.6(2).

c. Received a statement regarding Medicaid eligibility and benefits that shall be in the following format:

NOTICE TO APPLICANT
REGARDING MEDICAID ELIGIBILITY

I understand that eligibility for Medicaid is not automatic; an application is necessary. My insurance company will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any asset exemptions available to any Iowan applying for Medicaid. I understand that should I wish to apply for public assistance it is my responsibility to apply for Medicaid. I further understand that before receiving Medicaid I will first have to use any additional assets I have not protected. I will also need to meet Medicaid's criteria for medical necessity which may be different from the eligibility criteria used by my private insurance. Once I become a Medicaid recipient, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medicaid services at that time may not be the same services I was receiving under my private long-term care insurance.

_____
(Signature of Applicant(s))

d. Agrees to the release of information by the issuer to the state as may be needed to evaluate the Iowa long-term care asset preservation program and document a claim for Medicaid asset protection, in the following format:

CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care policy or certificate by the [insert issuer name] to the Iowa department of human services for the purposes of documenting a claim for asset protection under the state Medicaid program, evaluating the Iowa long-term care asset preservation program, and meeting Medicaid audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the state of Iowa.

(Signature of Applicant(s))

e. Received a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

In order for this long-term care policy [certificate] to remain certified by the state of Iowa and qualify to provide asset protection for the state Medicaid program, daily coverage benefits must meet or exceed standards established by the state of Iowa. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy [certificate]. [Insert issuer name] will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy that increases benefits over the policy period and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy [certificate] losing its certified status and no longer being allowed to provide asset protection. It is [insert issuer name]'s responsibility to automatically inflate coverage benefit levels in order to maintain certified status; it is your responsibility to make premium payments in order to maintain certified status.

f. Received a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

72.5(3) Report to the commissioner of the division of insurance all sales involving replacement of existing policies and certificates by certified policies or certificates within 30 days of the issue date of the newly issued certified policy or certificate. The report shall include the following:

a. The name and address of the insured.

b. The name of the company whose policy or certificate is being replaced.

c. The name of the producer replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

72.5(4) Provide producer training as follows:

a. Provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless the producer has completed training covering at least the division's eight-credit outline on the Iowa long-term care asset preservation program.

b. Issuers shall provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless, on an annual basis, the producer completes two hours of continuing education training specifically covering the Iowa long-term care asset preservation program and Medicaid.

c. Issuers shall use only curriculum and instructors approved by the division of insurance. Coursework must be completed in a classroom setting and may not be completed on a "take-home" basis.

d. Issuers shall submit training courses used for continuing education for approval to the outside vendor under contract with the division of insurance at least 30 days prior to the beginning of the course. Requests received later may be disapproved.

72.5(5) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE IOWA LONG-TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE

BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM."

72.5(6) Long-term care insurance policies or certificates sold after July 1, 1994, that are not certified under the Iowa long-term care asset preservation program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705."

72.5(7) Provide that no qualified long-term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner.

72.5(8) Except as provided in this subrule, an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months. The following describe the process and result of discontinuing the availability of a policy form or certificate form:

An issuer may discontinue the availability of a policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. The following shall be considered a discontinuance of the availability of a policy form or certificate form:

a. The sale or other transfer of a qualified policy form or certificate form to another issuer.

b. A change in the rating structure or methodology unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(3) An issuer that discontinues the availability of a policy form or certificate form under this subrule shall not file for approval of a new long-term care policy form or certificate form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if: an issuer discontinues a policy form or certificate form as the result of changes to this rule; or all existing policyholders and certificate holders of a discontinued policy form or certificate form are given the opportunity to purchase the new policy form or certificate form without regard to health status, claims experience, or age. Issuers are not required to make this offer to policyholders or certificate holders receiving benefits under the discontinued policy form or certificate form.

191—72.6(249G) Minimum benefit standards for qualifying policies and certificates. No long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long-term care insurance policy or certificate which does not meet the minimum benefit standards in this rule, and which has not been approved by the division of insurance as a qualified long-term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements for long-term care insurance policies or certificates. In order to qualify

for participation in the Iowa long-term care asset preservation program, a long-term care insurance policy or certificate shall meet the following:

72.6(1) Contain a "benefit amount maximum" equivalent to at least 365 times the minimum daily nursing facility benefit defined in 72.6(6)*"a."*

72.6(2) Offer a maximum benefit amount option equivalent to 365 times the minimum daily nursing facility benefit defined in 72.6(6)*"a."* Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

72.6(3) Provide that maximum benefits be available in dollars and not in days of care.

72.6(4) Include a provision of inflation protection which satisfies at least one of the following criteria:

a. The policy or certificate covers at least 80 percent but not more than 110 percent of the average daily private pay rate.

b. The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the consumer price index or at 5 percent each year over the previous year for each year that the contract is in force.

c. The policy or certificate provides the following:

(1) Annual per diem upgrades on a guaranteed issue basis at premiums based on the age of the policyholder or certificate holder at the time of the issuance of the qualified policy or certificate.

(2) Unless the insured takes positive action to decline them, these upgrades automatically increase the level of daily coverage to meet or exceed the minimum inflation adjusted daily benefit. The minimum inflation adjusted daily benefit is defined as the amount or amounts derived by taking the minimum daily benefit for nursing facility care at the time of purchase as specified in 72.6(6)*"a"* and inflating it by the consumer price index or by at least 5 percent each year over the previous year for each year that the contract is in force. The schedule of minimum per diem dollar amount increases shall be updated and maintained at the division of insurance.

(3) The issuer shall notify those policyholders or certificate holders choosing the upgrade option when the upgrades are automatically effective and what the increased premium, if any, will be. The issuer shall also provide to the policyholder or certificate holder, at the time of the upgrade, the opportunity to decline the upgrade.

(4) The issuer shall notify the policyholder or certificate holder when the insurance policy or certificate will lose its qualification status if the annual per diem benefit upgrade is declined. A qualified policy or certificate containing this inflation protection provision will remain qualified as long as the insured's daily benefit amount equals or exceeds the minimum inflation adjusted daily benefit.

72.6(5) Provide that the unused maximum benefit amount of the policy or certificate increase proportionately with the inflation protection requirements of 72.6(4).

72.6(6) At a minimum, upon the initial effective date, provide the following:

a. A daily nursing facility benefit of at least 80 percent of the average daily private pay rate in nursing facilities rounded to the next highest $5 increment. No policy or certificate need pay benefits in excess of the actual charges.

b. A daily home- and community-based benefit of at least 50 percent of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate need pay benefits in excess of the actual charges.

c. The daily home- and community-based benefit shall not exceed the daily nursing facility benefit.

72.6(7) If issued on an expense incurred basis, provide benefits which are equal to at least 80 percent of the per diem cost incurred by the insured.

191—72.7(249G) Required policy and certificate provisions.

72.7(1) All qualified policies and certificates shall meet the following requirements:

a. Have premiums:

(1) Based on the issue age of the applicant; or

(2) Level for the life of the policy or certificate with an adjustment only for the increased benefits resulting from the inflation protection requirements of subrule 72.6(4). Nothing in this rule shall preclude

an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

b. Not have premiums based on the attained age of the insured.

c. Include a provision that the policy or certificate will utilize the "insured event" criteria, defined in 72.3(249G) for determining eligibility for benefits and for determining the amount of asset disregard. Approval for admission to a nursing facility under the "preadmission screening program," as defined in 72.3(249G) shall be deemed sufficient but not necessary to meet this insured event criteria.

d. Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home- and community-based care. Home- and community-based care shall include, at a minimum, but not be limited to, the following:

(1) Home health nursing.
(2) Home health aide services.
(3) Attendant care.
(4) Respite care.
(5) Adult day care services.

All home- and community-based services shall include case management services delivered by a case management agency. An asset disregard will be provided for all benefits used by qualified insureds to purchase "Medicaid-eligible long-term care services" as defined in 72.3(249G).

e. Include a provision which allows for a 30-day period within which coverage may be canceled by the applicant by delivering or mailing the evidence of coverage to the issuer or the producer through whom it was effected for a full refund of any premium that was paid. The policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate to the issuer or its producer for cancellation within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Include a provision which, in the event the qualified policy or certificate is about to lapse or the policy or certificate is about to lose qualification status under 72.6(4)*"c"*(4), offers the policyholder or certificate holder the option to reduce coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in 72.6(1). The issuer need only allow this offer to be exercised one time. Premiums shall be based on the age of the policyholder or certificate holder at the time of the issuance of the original qualified policy or certificate.

g. Include a provision which, in the event a policyholder or certificate holder lapses a qualified policy or certificate and retains a nonforfeiture benefit, the policy or certificate will maintain its qualification status only so long as the minimum inflation adjusted daily benefit, as defined in 72.6(4)*"c"*(2), is met or exceeded or the policy or certificate pays at least 80 percent of actual or reasonable charges, and the total of the benefit amount paid to date and the benefit amount available is not less than 365 times the minimum inflation adjusted daily benefit. If at any point while in a nonforfeiture benefit the criteria in this paragraph are not met, the policy or certificate will lose its qualification status and the issuer shall notify the policyholder or certificate holder and the department of insurance of the loss of qualification.

h. Include a provision that, upon sale of a qualified long-term care insurance policy or certificate, the issuer shall do the following:

(1) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no sooner than 30 days after the beginning of the 30-day grace period for premium payments. The issuer shall permit the policyholder or certificate holder to periodically update the authorized designee. In the case of an applicant who elects not to designate an additional person, the waiver shall state:

Protection against unintended lapse.

I understand that I have the right to designate at least one authorized designee other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

(2) Provide at least a five-month guaranteed reinstatement period for a policyholder or certificate holder whose policy or certificate has lapsed due to nonpayment of premium, who has a cognitive impairment, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

i. Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificate holder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare. An asset disregard will only be provided for benefits the issuer can document were used to purchase Medicaid-eligible long-term care services as defined in 72.3(249G) for a qualified insured.

j. Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long-term care policy shall not be changed or otherwise modified without the signed acceptance of the certificate holder.

72.7(2) Reserved.

191—72.8(249G) Prohibited provisions in certified policies or certificates. The following provisions may not be included in a certified policy or certificate: a restoration of benefits; a second elimination period; any cap on the daily (as opposed to monthly) home- and community-based care benefits.

191—72.9(249G) Reporting requirements. Unless otherwise noted, the requirements of this rule refer to issuer documentation and reporting requirements for qualified policies and certificates. The reports shall be submitted for each person entitled to benefits under a qualified policy or certificate. Each issuer shall do the following:

72.9(1) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa, a report to the department of human services that will include the following information on all individuals who purchased a qualified policy or certificate during the reporting period:

a. Name, address, telephone number, date of birth, sex, marital status, and social security number.

b. Policy or certificate identification information, including the following:

(1) The policy or certificate form number.

(2) The policy or certificate number.

(3) The policy or certificate category.

(4) The effective date of coverage.

c. Policy or certificate elimination period in days by type of service.

d. The maximum daily benefit for nursing facility care and for home- and community-based care.

e. Maximum lifetime benefit amounts.

f. Any options and riders in force.

g. Purchase type (upgrade, conversion or new issue).

h. Method used for calculation of the inflation protection benefit.

i. For expense incurred policies or certificates, the percentage of expenses payable.

j. The annual premium for the policy or certificate, the premium mode (monthly, bank draft, quarterly), and the type of premium calculation (level, issue age, other).

72.9(2) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who have changed or amended qualified policies or certificates during the reporting period:

a. Name, address, telephone number, and social security number.

b. Effective date of the policy or certificate change or coverage amendment.

c. A description of the new policy or certificate or amended policy or certificate as described in 72.9(1).

72.9(3) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who dropped their policies or certificates during the reporting period:

a. Name, address, telephone number, and social security number.

b. The date the policy or certificate was dropped.

c. The reason the policy or certificate was dropped, including any of the following:

(1) Death of insured.

(2) Converted policy or certificate.

(3) Maximum benefits expended.

(4) Recision.

(5) Voluntarily.

(6) Qualification of the policy or certificate lost.

(7) Other.

(8) Unknown.

72.9(4) Maintain a registry and submit on a quarterly basis in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who are denied a qualified policy or certificate during the reporting period:

a. Name, address, telephone number, date of birth, sex, marital status and social security number.

b. Reason for denial of the application, including the following:

(1) Application was not complete.

(2) Age was not in allowable range.

(3) Eligibility for Medicaid.

(4) Medical or other reasons.

(5) Other.

72.9(5) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who were assessed for long-term care and benefit eligibility during the reporting period:

a. Name, address, telephone number, and social security number.

b. Date the assessment was conducted.

c. Name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for asset protection.

d. A listing of the insured event criteria met for all persons assessed, including complex, unstable medical conditions, deficiencies in activities of daily living, and cognitive impairment.

72.9(6) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on each service used and benefits claimed during the reporting period for each insured:

a. Name, address, telephone number, and social security number.

b. Whether the policyholder or certificate holder was currently enrolled in Medicare Parts A and B (42 U.S.C. 1395 et seq.) and either:

(1) A beneficiary of a Medicare supplement insurance policy or certificate approved by the division of insurance.

(2) Enrolled in a prepaid health care delivery plan that provides acute care and preventive service; or

(3) Covered under a contract under Section 1876 or 1833 of the Social Security Act (42 U.S.C. 1395 et seq.).

c. Service or procedure code.

d. Whether the claim for the service was denied or approved.

e. Start and end date for the service.

f. Number of units of service and amount billed.

g. Amount paid by the policy or certificate and the amount paid which counts toward the asset protection.

72.9(7) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on the following aggregate information for the reporting period:

a. The number of applications for qualified long-term care insurance policies and certificates received during the quarter.

b. The number of persons denied a qualified policy or certificate and the reason for denial. Reasons for denial to be specified include the following:

(1) Application was incomplete.
(2) Age was not in allowable range.
(3) Eligibility for Medicaid.
(4) Medical or health reasons.
(5) Other.

c. The number of qualified policies and certificates purchased during the quarter.

d. The number of qualified policyholders and certificate holders who dropped their qualified policy or certificate during the quarter for any of the following reasons:

(1) Death of insured.
(2) Converted policy or certificate.
(3) Maximum benefits expended.
(4) Recision.
(5) Voluntarily.
(6) Qualification of the policy or certificate lost.
(7) Other.
(8) Unknown.

e. The number of beneficiaries of qualified policies and certificates in force at the end of the quarter.

191—72.10(249G) Maintaining auditing information.

72.10(1) Each issuer shall maintain information as stipulated in 72.10(6) on all policyholders or certificate holders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificate holder's condition which is not otherwise required by federal or state statute or regulation.

72.10(2) When a policyholder or certificate holder who has received any benefit dies or lapses the policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five years after the time when the policy was in force. Unless notified by the division of insurance to the contrary during this period, after the five years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost-effective method of record storage as alternatives to storage of paper copies of stipulated information.

72.10(3) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificate holder of the right to request service records as stipulated in 72.10(6).

72.10(4) The issuer shall also, upon request in writing, provide such policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if any, with a copy of the issuer's service records as required in 72.10(6) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if requested, within 60 days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

72.10(5) The issuer shall enclose with the records a statement advising the former policyholder or certificate holder that it is in the best interest of the former policyholder or certificate holder to retain the records to establish eligibility for Medicaid.

72.10(6) The information to be maintained includes the following:

a. Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(1) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(2) By an assessment conducted as part of the preadmission screening program of the Iowa Foundation of Medical Care.

(3) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(4) For persons for whom subparagraphs (1) through (3) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (1) through (3). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

b. Description of services provided under the policy or certificate, including the following:

(1) Name, address, telephone number, and license number, if applicable, of provider.

(2) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(3) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(4) The charges of the service providers, including copies of invoices for all services counting toward asset protection.

(5) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(6) Determination of whether the policyholder or certificate holder was a qualified insured at the time of benefit payment. The issuer may rely on written representation by the policyholder or certificate holder as to whether the required coverages were held.

c. In order for home- and community-based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificate holder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(1) A copy of the original plan of care.

(2) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count toward asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count toward asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

191—72.11(249G) Reporting on asset protection.

72.11(1) Each issuer shall send an asset protection report at least quarterly to each policyholder or certificate holder who has received any benefits since the last asset protection report sent to the policyholder or certificate holder. Each asset protection report shall include the following information:

a. The amount of asset protection for which the policyholder or certificate holder had qualified prior to the quarter covered by the report.

b. The total benefits paid by the issuer for services rendered during the quarter.

c. A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

d. A summary total of the amount paid to date under the policy or certificate which qualifies for asset protection.

72.11(2) Asset protection reports shall be subject to audit by the division of insurance under the same requirements as specified in 72.13(1)*"b."*

191—72.12(249G) Preparing a service summary.

72.12(1) Each issuer shall prepare a service summary at the client's request specifically for the policyholder or certificate holder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificate holder has exhausted benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificate holder, whichever occurs first.

72.12(2) The service summary shall identify the following:

a. The specific qualified policy or certificate.

b. The total benefits paid for services rendered to date.

c. The amount qualifying for asset protection.

This service summary is separate and in addition to any other information requirement in this chapter.

191—72.13(249G) Plan of action.

72.13(1) Each issuer shall, prior to qualification by the division of insurance, submit to the department of human services a plan for complying with the information maintenance and documentation requirements set forth in rules 72.9(249G) and 72.10(249G). No policy or certificate shall be qualified until the department of human services has approved the issuer's documentation plan for the policy or certificate. The documentation plan will include the following:

a. The location where records will be kept. Records required for purposes of the Iowa long-term care asset preservation program must be available at no more than three locations, each of which shall be easily accessible to the division of insurance.

b. The issuer shall agree to give the commissioner access to all information described in rule 72.10(249G) on an aggregate basis for all policyholders or certificate holders and on an individual basis for all policyholders or certificate holders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the commissioner to determine if an issuer's system for documenting asset protection is functioning correctly. The commissioner shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

c. The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the department of human services and the division of insurance concerning the information.

d. Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

(1) Documentation of the insured event.

(2) Description of services.

(3) Documentation of charges and benefits paid.

(4) Documentation of plans of care, when required.

e. Description of electronic and manual systems which will be used in maintaining the required information.

f. Information that will be retained which is needed to comply with this rule.

g. Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

72.13(2) After the department of human services reviews a plan of action, that department shall advise the division of insurance and the issuer in writing whether the department of human services approves the plan of action. If the department of human services disapproves a plan of action, that

department shall advise the division of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them.

191—72.14(249G) Auditing and correcting deficiencies in issuer record keeping.

72.14(1) Within one year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner of insurance or department of human services deems necessary thereafter, the commissioner of insurance or department of human services shall conduct a systems audit of that company's records. The issuer shall be responsible for advising the department of human services and the division of insurance when this one-year period has begun. The commissioner or department of human services shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation.

72.14(2) The department of human services shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. The department of human services shall have the final decision concerning sample sizes and other auditing methods. The department of human services shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. The department of human services shall also notify the issuer of any obligations described in this subrule to hold clients harmless.

72.14(3) The department of human services may enter into voluntary arrangements with issuers of qualified long-term care insurance policies and certificates under which the department of human services would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the department of human services concerning whether services qualify for asset protection shall be binding upon the department of human services in all subsequent actions, and the department of human services shall not make any assertion contradicting these determinations in any action arising in this subrule:

a. All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the department of human services in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

(1) Whether the insured event has occurred and has been adequately documented.

(2) Whether a care plan is required.

(3) Whether a revision of a care plan is required.

(4) Whether a service or services are in accord with the care plan.

(5) Whether a service is of such a nature as to qualify for asset protection.

(6) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

b. The department of human services or one of its other authorized individuals may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

(1) Assessments.

(2) Care plans.

(3) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information is later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the department of human services or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of 72.14(6) and 72.14(7) will apply in the same manner as for any other policyholder or certificate holder.

c. The department of human services or its authorized individual shall render a determination on each request in writing. Each determination of the department of human services or its other authorized individual shall state the reason for the determination, including the following:

(1) Relevant facts.
(2) Documentation of facts.
(3) Statutes.
(4) Regulations.
(5) Policies.

d. A copy of all determinations of the department of human services or its authorized individual shall be kept on file at the department of human services, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized producer.

72.14(4) When an audit or other review by the department of human services or the division of insurance reveals deficiencies in the record-keeping procedures of an issuer, the department of human services or the division of insurance will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by the department of human services within a reasonable period of time, the department of human services will notify the division of insurance of the deficiencies. If an issuer fails to correct deficiencies discovered by the division of insurance within a reasonable period of time, the division will notify the department of human services of the deficiencies.

72.14(5) The commissioner of insurance shall reserve the right to remove qualification status of long-term care insurance policies and certificates when deemed necessary. If the division of insurance removes qualification status from a long-term care insurance policy or certificate, a policyholder or certificate holder who purchased a policy or certificate while the policy or certificate was qualified will retain the right to asset protection. A policyholder or certificate holder who purchases a policy or certificate after the removal of qualification status will have no right to asset protection.

72.14(6) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(7) If the department of human services determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that the department of human services cannot determine whether the policyholder or certificate holder qualifies for asset protection, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(8) The commissioner of insurance and the department of human services shall consult on all audits and examinations that may be required to determine compliance with this rule.

72.14(9) Compliance with 72.14(6) and 72.14(7) is a requirement for a policy or certificate to retain qualification.

191—72.15(249G) Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code Supplement chapter 249G.

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CHAPTER 73
HEALTH INSURANCE PURCHASING COOPERATIVES

191—73.1(75GA,ch158) Purpose. The purpose of this chapter is to implement 1993 Iowa Acts, chapter 158, section 2, authorizing the creation of privately established and operated health insurance purchasing cooperatives, subject to regulation by the division of insurance. The purpose of the health insurance purchasing cooperatives is to improve the quality, access, and affordability of health care by more effectively representing the interests of buyers and consumers and creating a value conscious market. Health insurance purchasing cooperatives as described in the Insurance Division's oral and written briefings, the Pooled Purchasing Group Subcommittee Report, and Jackson Hole papers relied upon by the legislature effectively organize buyers of insurance, risk management, and health care services to negotiate price and quality with sellers of insurance, risk management, and health care services, whether the sellers are organized as insurance companies, health maintenance organizations, or other legally permissible structures.

191—73.2(75GA,ch158) Applicability and scope.

73.2(1) This chapter shall apply to all health insurance purchasing cooperatives operating in this state. However, this chapter shall not apply to any other health insurance or health care marketing, distribution or purchasing mechanism otherwise permitted by law.

73.2(2) A health insurance purchasing cooperative under this chapter is exempt from any law in this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that discriminates against a purchasing group or its members. An insurer is exempt from any law of the state that prohibits providing or offering to provide, to a purchasing group or its members, advantages based upon their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverage, or other matters. A purchasing group is subject to all other applicable laws of this state including Iowa Code chapter 522.

73.2(3) An entity not approved by the division as a HIPC and engaged in the purchase, sale, marketing or distribution of health insurance or health care plans shall not hold itself out as a HIPC, health insurance purchasing cooperative, purchasing cooperative, or otherwise use a confusingly similar name or marketing materials; and a nonapproved entity that does so shall be in violation of this chapter and subject to penalties under Iowa Code chapter 507B. This subrule is not intended to restrict the activities of a purchasing coalition of ERISA-qualified, self-funded employers engaged in the purchase of health care from providers on a nonrisk-bearing basis.

191—73.3(75GA,ch158) Definitions. As used in this chapter:

"Adjusted community rating" means a method used to develop a carrier's premiums which spreads financial risk across a large population and allows adjustments only for certain demographic factors and family composition as provided by state law for insurance carriers providing services to the same consumer or as otherwise approved by the commissioner to accommodate the unique characteristics of a health insurance purchasing cooperative.

"Business plan" means the plan of operation of the health insurance purchasing cooperative.

"Carrier" means any entity that provides health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, an organized delivery system, and any other entity providing a plan of health insurance or health benefits subject to state regulation.

"Commissioner" means the commissioner of insurance for the state of Iowa.

"Division" means the insurance division of the state of Iowa.

"Health insurance purchasing cooperative" means a group of individuals, a group of employers and employees, or a combination of individuals and employers and employees who join together to purchase health insurance or health care benefits.

"HIPC" means health insurance purchasing cooperative. This acronym shall be used interchangeably with the words "health insurance purchasing cooperative" throughout this chapter.

"HIPC administrator" means a person or organization charged with overseeing the day-to-day operations of a HIPC.

"HIPC sponsor" means an employer, group of employers, or private agent authorized under this chapter to facilitate the purchase of insurance and health care services for participating employers and employees.

"Organized delivery system" means a plan as set forth in rules of the public health department, 641—Chapter 201.

"Service territory" means any of the following:

1. A regional HIPC as identified by the commissioner. A regional HIPC serves a defined regional market which shall at minimum include the surrounding rural market of any city included in the regional HIPC.

2. A statewide HIPC as identified by the commissioner shall offer service throughout the state. A statewide HIPC may establish regional service areas, governance and negotiations, provided those structures conform to the provisions of paragraph "1."

"Small employer" means an employer as defined in Iowa Code section 513B.2.

191—73.4(75GA,ch158) Division duties—application—filing requirements—license—audits and examinations.

73.4(1) The division shall have the authority to regulate the establishment and conduct of a HIPC as set forth in this chapter.

73.4(2) A HIPC shall not operate in Iowa without an approved license from the division. An application form shall be completed and signed by an authorized representative of the HIPC sponsor and proposed HIPC administrator (if applicable). The completed application form shall be verified and filed at the division. An application will not be deemed to be filed until all information necessary to properly process the application has been received by the commissioner. Upon filing, the division will make its determination concerning the application and will provide notice of the determination to the HIPC. If approved, a copy of the approved license shall be provided to the HIPC sponsor. The license shall serve as the HIPC's authorization until the yearly renewal date. Any amendment to the license shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

73.4(3) Each HIPC doing business in the state shall file with the division the following information or documents:

a. A business plan for approval by the commissioner as provided in rule 73.7(75GA,ch158). The business plan is a detailed, written plan of operations explaining how the proposed HIPC intends to meet the public policy objectives of reduced cost, increased access and improved quality. The business plan is a written commitment by the HIPC if approved. Failure to comply with the business plan is a basis for license suspension or revocation. Material changes in policy or operations are subject to the prior approval of the commissioner on the same basis as the original business plan.

b. Quarterly financial statements and annual reports on forms approved by the commissioner. Financial statements and annual reports are to ensure the operation of the HIPC in a fiscally sound fashion; to ensure the HIPC is not a risk-bearing entity; to ensure sound financial controls and money management; and to prevent mismanagement or misappropriation of funds either through neglect or malfeasance.

c. Reports of any material changes in the business plan or operation. The changes are subject to approval by the commissioner prior to implementation. The original business plan is the basis of licensure. Material changes in the business plan therefore require similar prior approval by the commissioner.

d. Any other information required by the commissioner deemed pertinent to the operation of a HIPC in the state. The specifics of a business plan, market conditions, enforcement cases, or other issues may make it necessary for the commissioner to gather additional information to make an informed decision in the public interest. Failure to provide requested information is a basis for denial, suspension or revocation of a license.

e. A HIPC shall not enter the market place until the commissioner has approved the business plan.

73.4(4) Financial and performance audits or examinations of the HIPC shall be conducted on a regular basis by the division. Failure to meet minimum standards in a financial or performance audit or examination is the basis for license denial, suspension or revocation, or other action to protect consumers. The commissioner may impose conditions on licensure such as, but not limited to, the removal and replacement of managerial or marketing staff or contractors to remedy compliance or performance problems.

191—73.5(75GA,ch158) Fidelity bond—letter of credit. A HIPC shall maintain in force a fidelity bond on administrators, employees and officers in an amount not less than $1,000,000 or such greater sum as may be prescribed by the commissioner. The fidelity bond shall be in the form prescribed by the commissioner. In the event a HIPC employs a contract administrator, the administrator shall maintain a $250,000 letter of credit for the life of the contract payable to the HIPC sponsor. This letter of credit shall be in addition to the fidelity bond.

191—73.6(75GA,ch158) Annual report. The commissioner shall submit an annual report to the general assembly no later than February 1 of each year. The report shall include a description of the operations of all health insurance purchasing cooperatives, a review of the success of health insurance purchasing cooperatives as it pertains to improving the quality, access or affordability of health insurance. The commissioner may require HIPCs to provide information in uniform format for use in compliance with this report and for other public purposes.

191—73.7(75GA,ch158) Business plan. A HIPC shall submit its business plan for the prior review and approval by the commissioner. The business plan shall include but shall not be limited to the following information:

73.7(1) The specific steps by the HIPC sponsor to advance cost control, quality improvement, and improve access to health insurance or health care services. The business plan should affirmatively demonstrate that the HIPC has the technical expertise and physical capacity to serve as a significant group of buyers not currently being served by a HIPC. Significant means at least 10 percent of the population within the proposed service territory. The business plan should affirmatively demonstrate that the HIPC will reduce cost, improve quality and improve access to health insurance or health care services.

73.7(2) The scope of HIPC services to be offered in the service territory and the resources and expertise to be used to implement and administer the plan. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to serve a significant group of buyers over a wide territory, encompassing at minimum a regional health care center and its associated rural market. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to provide equal service quality throughout the entire HIPC service territory.

73.7(3) The corporate charter, bylaws and other business operation documents of the HIPC. As a condition of licensure the HIPC must demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of buyers' interests within the service territory. A HIPC must be more than a marketing or distribution channel for a single product or the products of a single carrier. A HIPC as a condition of licensure must organize and facilitate competition between multiple insurers or health care providers.

73.7(4) A list of officers and directors of the HIPC and the contract administrator if one is employed and personal biographical information or firm descriptions for each. The officers, directors, or contract administrator shall not have a prior record of administrative, civil or criminal violations within any financial service industry. The personal biographical information and firm descriptions shall demonstrate by clear and convincing evidence that those involved in the HIPC have the expertise, experience and character to effectively and professionally represent buyers in a fiduciary capacity.

73.7(5) Evidence of adequate security and prudence in the accounting, deposit, collection, handling and transfer of moneys. Because the HIPC may handle payments or accounting, the HIPC must

affirmatively demonstrate adequate financial controls to the satisfaction of the division as a condition of licensure. Failure to have adequate controls or failure to follow approved procedures shall be a basis to deny, suspend, or revoke licensure.

73.7(6) The market segments and participants to which the HIPC will be marketing. The HIPC must demonstrate to the satisfaction of the commissioner that it will extend HIPC services to a significant group of buyers not currently served by a HIPC. Failure to achieve this result can be the basis of later denial to renew a license.

73.7(7) Disclosure of any preexisting oral or written agreements. Preexisting agreements may raise questions of conflict or demonstrate the intention to create a marketing channel for a single product or single carrier. Conversely, preexisting agreements may assist in affirmatively demonstrating technical or physical capacity to serve a service territory or to extend HIPC services to a significant group of buyers not currently served by a HIPC. Regardless, any preexisting oral or written agreements must be disclosed. Failure to disclose an agreement is the basis for license denial or revocation.

73.7(8) Any other information required by the commissioner to verify the HIPC is qualified.

191—73.8(75GA,ch158) Participants. A HIPC may offer services to any of the following participants:

1. Individuals.
2. A small business as defined in 191—Chapter 71.
3. A business with more than 50 employees.
4. An association and its members.
5. The state or a local government unit.
6. Any other purchaser on a voluntary basis.

Underwriting standards shall be no more restrictive than required of small group health insurance under 191—Chapter 71.

A HIPC's business plan may impose conditions or limitations on members leaving the HIPC to protect against adverse selection. A HIPC shall accept all entities within its chosen market segment in accordance with the regulations governing marketing of insurance to that market segment, e.g., individual, small group, or large group.

A HIPC may provide services to participants out-of-state or out-of-region who elect to join for the benefit of representation and participation in health insurance or health care benefits only when an employer out-of-state or out-of-region has employees within the state or region or an individual is required to have coverage in the state or region due to specific circumstance.

191—73.9(75GA,ch158) Health insurance purchasing cooperative—product offerings—exemptions.

73.9(1) A HIPC shall offer at least one indemnity plan which provides an unrestricted choice of a physician. However, the indemnity plan may require an appropriate utilization review, preauthorization of treatments, or other reasonable cost and utilization oversight.

73.9(2) All small employer group carriers participating in a HIPC shall offer a basic and a standard benefit plan.

73.9(3) A HIPC is not required but may offer an employer-choice managed health care plan. The HIPC may also offer other indemnity plans.

73.9(4) A HIPC cannot offer insurance from a risk retention group not chartered in the state nor a carrier not admitted in the state.

73.9(5) A HIPC shall retain agents who are licensed pursuant to Iowa law if the HIPC markets the products of the HIPC through agents or sales representatives. Alternatively, if the HIPC does not use sales agents or representatives, the HIPC must demonstrate to the satisfaction of the commissioner that the alternative will provide consumer service meeting the same standards as that required of agents.

73.9(6) A participating health plan is not required to be offered outside of the HIPC but may be offered through other distribution or marketing channels. An entity may not be licensed as a HIPC if it offers only one health plan or the products of only one carrier, or related carriers.

191—73.10(75GA,ch158) Insurance risk. A HIPC shall bear no insurance risk. The HIPC shall facilitate the purchase of insurance and health care services. Provisions for participants to retain risk through deductibles, retention levels, or partial or complete self-funding shall be disclosed and shall be subject to approval by the commissioner prior to implementation to ensure that risk is not borne by the HIPC.

191—73.11(75GA,ch158) Rates.

73.11(1) A carrier shall use rate restrictions and regulations applicable to each market segment.

73.11(2) The HIPC may collect a different premium within the HIPC. This difference is predicated on marketing and administrative expenses which the HIPC would assume. Therefore, the carrier could offer the HIPC a lower final rate than the carrier would charge outside of the HIPC.

191—73.12(75GA,ch158) Election—disclosure and confidentiality.

73.12(1) A HIPC may elect to preclude for a period of time a participant who leaves the HIPC from returning to the HIPC to purchase health insurance or health care benefits. However, a HIPC shall not use this subrule to discriminate against high-risk participants.

73.12(2) Subject to review and approval by the commissioner, a HIPC may provide restricted access to information in its possession which is essential to the operation of the HIPC.

Confidentiality must:

a. Be an inducement for voluntary participation in the program;

b. Protect the privacy of participants;

c. Protect negotiating strategy from disclosure to contractors or competitors; or

d. Protect proprietary information in like circumstances as for insurance.

191—73.13(75GA,ch158) Structure—merger and consolidation.

73.13(1) A HIPC shall be a legal entity which operates on behalf of its sponsor or participants.

73.13(2) A HIPC shall disclose its total administrative cost in its annual report to the commissioner in the same manner and on the same basis as insurance carriers.

73.13(3) The change in control, merger or acquisition of a HIPC is subject to the prior review and approval of the commissioner on the same terms as a change in control, merger or acquisition of an Iowa domestic insurance company.

191—73.14(75GA,ch158) Conflict of interest.

73.14(1) Health care providers or insurers offering competing products within the same service territory shall not participate in a HIPC as a sponsor. A HIPC sponsor employing a HIPC administrator that offers competing products within the same service territory shall demonstrate to the satisfaction of the commissioner precautions to protect the HIPC from unfair competition or disclosure of proprietary information.

73.14(2) A HIPC sponsor shall not be an employee or be affiliated with or a subsidiary of a health care provider or insurer offering competing products within the same service territory.

73.14(3) The employees of a health care provider or insurer may receive services through a HIPC. The employer may vote in corporate governance elections of officers and directors. However, a health care provider or insurer or an employee of a health care provider or insurer may not serve as an officer of a HIPC. A health care provider or insurer or the employee of a health care provider or insurer may be a director of a HIPC or HIPC sponsor, but such persons shall not constitute a majority of the governing board or body of a HIPC or HIPC sponsor.

73.14(4) Compensation to the HIPC's sponsor, administrator, or agents shall not vary based upon the plan selected by participating members.

191—73.15(75GA,ch158) Nondiscrimination and retaliatory protections. An insurer shall not discriminate against or take retaliatory action against a participant employer, employee, agent, sponsor, or administrator of a HIPC. A HIPC shall not discriminate against or take retaliatory actions against an insurer or agent for activities relating to the HIPC.

191—73.16(75GA,ch158) Annual health insurance or health care benefits plan selection. A HIPC shall offer participants an opportunity at least once annually to change health insurance or health care benefits. The HIPC shall determine whether the change in health insurance or health care benefits may be made by the individual employees of an employer participant or by the employer participant on behalf of the employer's employees. The HIPC shall provide pertinent available information including cost and quality of risk management services on health insurance and health care benefits offered to assist the participants in making an informed decision in the selection of health insurance or health care benefits.

191—73.17(75GA,ch158) License subject to conditions—waivers. A new participating buyer shall join when the plan is offered to them or at the annual open enrollment.

73.17(1) The commissioner may limit the number of HIPCs licensed within a geographic service territory. A HIPC must demonstrate probable success in representing a substantial share of the purchasers within the proposed service territory and that it is likely to largely represent purchasers not already served by existing HIPCs within the same service territory. The commissioner may refuse to renew or condition the license of a HIPC that fails in actual operations to achieve these requirements.

73.17(2) Existing HIPCs may present evidence of the anticipated impact of a new HIPC within their geographic service territory to resist an additional licensee. This shall include but is not limited to evidence that the new HIPC will use risk selection against an existing HIPC and the new HIPC will adversely dilute the market leverage of an existing HIPC. The division shall provide notice to existing HIPCs of an applicant's filing. Existing HIPCs must file notice of intent to submit evidence within ten days of the notice. Existing HIPCs may request a hearing or submit evidence in writing.

73.17(3) The commissioner may impose risk adjustments between HIPCs within a geographic service area or between all HIPCs within the state to ensure competition based upon service and effective cost and quality control and not based upon risk selection.

73.17(4) The commissioner may impose additional conditions to protect the interests of participating buyers and consumers, ensure fair and efficient conduct of HIPC duties, and to protect HIPCs from adverse selection or bearing insurance risk.

73.17(5) The commissioner may impose additional conditions or waive restrictions for a specified period of time to facilitate orderly market transition to reform upon a showing of necessity by the applicant HIPC or upon the commissioner's own initiative.

191—73.18(75GA,ch158) Procedures. Actions by a HIPC before the division or the commissioner shall conform to the pertinent procedures set forth in the administrative rules of the insurance division.

191—73.19(75GA,ch158) Data collection—quality evaluation.

73.19(1) The HIPC shall conform to any pertinent reporting provisions of the community health management information system.

73.19(2) A HIPC shall conduct a qualitative review of plans offered through the HIPC in order to provide participating employers and employees an accurate comparative analysis of cost, quality, access, relative value, service, and customer satisfaction. The division may require HIPCs to cooperate in establishing a common basis and methodology for plan evaluation and customer education to facilitate informed choice between plans. A HIPC shall detail in its proposed business plan the methodologies and resources it intends to employ to satisfy this requirement. The HIPC must produce an annual report card on the performance of participating plans.

73.19(3) The division may establish data reporting standards to permit the objective evaluation of HIPCs and their impact on health care costs, quality and access.

191—73.20(75GA,ch158) Examination—costs. The commissioner shall examine a HIPC and may require the most recent audited financial statements from the administrator and such other interim evidence as the commissioner deems appropriate. Reasonable costs of the examination or audit are to be paid by the HIPC. Examination shall include, but not be limited to, premium collection, marketing practices, and financial condition.

191—73.21(75GA,ch158) Trade practices. A HIPC shall be subject to Iowa Code chapter 507B, Insurance Trade Practices.

191—73.22(75GA,ch158) Grounds for denial, nonrenewal, suspension or revocation of certificate. The following constitute grounds for denial, nonrenewal, suspension or revocation of the HIPC's certificate following notice and an opportunity for hearing:

1. Failure to comply with any provisions of the rules of this chapter;
2. Failure to comply with any lawful order of the commissioner;
3. Committing an unfair or deceptive act or practice as defined in Iowa Code chapter 507B;
4. Filing any necessary form with the division which contains fraudulent information or omission;
5. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or health care carrier or any organized delivery system otherwise not entitled to the HIPC and that have been entrusted to the HIPC in its fiduciary capacity;
6. Failure to demonstrate through clear and convincing evidence that it will extend HIPC services to a significant group of buyers not currently being served by a HIPC; or
7. Failure to demonstrate through clear and convincing evidence that it will reduce the cost, improve the quality, and improve access to or choice of affordable health insurance or health care services.

In addition, the application for certification to be a HIPC may be denied upon a finding by the commissioner that a sufficient number of HIPCs are licensed within a geographic service area and an additional HIPC would adversely affect existing HIPCs.

191—73.23(75GA,ch158) Hearing and appeal. Prior to denying an application or a renewal application or suspending or revoking a certificate issued under this chapter, a certificate holder shall be provided with written notice of the commissioner's decision and provided an opportunity for a hearing and a right to appeal as provided in rule 191—3.1(17A,502,505) and Iowa Code chapter 17A.

191—73.24(75GA,ch158) Solvency. In the event a HIPC becomes insolvent, the division shall maintain jurisdiction of the HIPC for purposes of protection of the interests of the HIPC participants and the health insurance carriers and health benefit plans pursuant to the pertinent sections of Iowa Code chapter 507C.

These rules are intended to implement 1993 Iowa Acts, chapter 158, section 2.

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CHAPTER 74
HEALTH CARE ACCESS

191—74.1(505) Purpose. The purpose of this chapter is to implement Iowa Code section 505.21 requiring an employer to provide access to health care or health insurance to an employer's eligible employees. The employer shall, at a minimum, make health care information or health insurance information available to the employer's eligible employees by a written referral. However, the employer may also satisfy the health care access requirement by offering or paying for health care or health insurance.

191—74.2(505) Applicability and scope. This chapter shall apply to all employers doing business within the state of Iowa.

191—74.3(505) Definitions. As used in this chapter:

74.3(1) *"Division"* means the insurance division of the state of Iowa.

74.3(2) *"Eligible employee"* means a natural person who is employed in this state for wages by an employer and works on a regular full-time or regular part-time basis. An eligible employee may include a commission salesperson who takes orders or performs services on behalf of a principal and who is paid on the basis of commissions but does not include persons who purchase for their own account for resale.

For purposes of this chapter:

a. An eligible employee does not include a temporary employee which means an employee who works for a limited period of time, or an employee with seasonal, intermittent, internship, trainee, or temporary status.

b. A minor as defined in Iowa Code chapter 599 is not an eligible employee.

c. The following persons engaged in agriculture are not eligible employees:

(1) The spouse of the employer and relatives of either the employer or spouse including relatives employed by a family farm corporation, a family farm partnership or family farm limited liability company.

(2) A person engaged in agriculture as an owner-operator or tenant-operator and the spouse or relatives of either.

(3) Neighboring persons engaged in agriculture who are exchanging labor or other services.

d. An independent contractor is not an eligible employee.

e. An individual working in vocational rehabilitation programs and receiving health care coverage through governmental programs is not an eligible employee.

74.3(3) *"Employer"* means a person, as defined in Iowa Code chapter 4, doing business in the state who in this state employs for wages a natural person. The term employer does not include a multiple employer trust or a client, patient, customer, or other person who obtains professional services from a licensed person who provides the services on a fee service basis or who obtains services from an independent contractor.

191—74.4(505) Access to health care or health insurance for an employee.

74.4(1) Access to health care or health insurance means any of the following:

a. An employer provides a written referral to an eligible employee as to where the eligible employee can receive information concerning health care or health insurance.

b. An employer offers coverage or contributes to health insurance or a health benefit plan.

74.4(2) An employer who provides the eligible employee a written referral, offers coverage or contributes under subrule 74.4(1) to any of the following has satisfied the health care access requirement.

a. Health care coverage through an insurer or health maintenance organization authorized to do business in Iowa.

b. Access to health benefits through a health benefits plan qualified under the federal Employee Retirement Income Security Act of 1974.

c. Joining a health purchasing cooperative as defined in 191 IAC 73 whereby the employees may purchase health insurance offered by several health insurance or health care benefit programs.

d. Any organized delivery system as defined in 641 IAC 201 or other form of health care delivery system.

74.4(3) To satisfy subrule 74.4(1), paragraph *"a,"* the employer shall contact a health insurance agent, health insurance carrier, or other health care organization which agrees with the employer to provide information to the eligible employee about health care or health insurance and possible purchase of health care or health insurance. In the event that an eligible employee cannot read or understand English, the employer shall offer assistance to the eligible employee in understanding the written referral. The employer shall provide the information to the eligible employee within a reasonable time of hiring the eligible employee.

191—74.5(505) Employer participation. The employer shall offer payroll deduction of the eligible employee's contributions to the health care program or health insurance program to which the employer referred the eligible employee. However, payroll deduction shall occur only if the eligible employee has adequate wages to pay the cost of the health care or health insurance. In the event that the insurance carrier or health care organization does not provide for payment through payroll deduction, an automatic withdrawal from the employee's savings or checking account shall comply with Iowa Code section 505.21.

191—74.6(505) Violation of chapter. A violation of this chapter may be reported to the consumer and legal affairs bureau of the division. The division, upon finding that the employer has failed to offer an eligible employee access to health care or health insurance, may do any of the following:

1. Issue a cease and desist order instructing the employer to cure the failure to provide access to health care and desist from future violations of this chapter.
2. Issue an order requiring the employer who has previously been the subject of a cease and desist order to pay an eligible employee's reasonable health insurance premiums necessary to prevent or cure a lapse in health care coverage due to the employer's failure to offer access to health care.
3. Assess the reasonable costs of the division's investigation and enforcement to the employer.

These rules are intended to implement Iowa Code section 505.21.

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CHAPTER 75
IOWA INDIVIDUAL HEALTH BENEFIT PLANS

191—75.1(513C) Purpose. This chapter is intended to implement the provisions of Iowa Code chapter 513C to promote the availability of health insurance coverage to individuals, regardless of their health status or claims experience; to prevent abusive rating practices; to require disclosure of rating practices to purchasers; to establish rules regarding the renewal of coverage; to establish limitations on the use of preexisting condition exclusions; to assure fair access to health benefit plans; to improve the overall fairness and efficiency of the individual health insurance market; and to provide for development of "basic" and "standard" health insurance plans to be offered to individuals. Carriers that provide individual health insurance benefit plans, as that term is defined in Iowa Code chapter 513C, to individuals are subject to all provisions of chapter 513C and this Chapter 75.

191—75.2(513C) Definitions. As used in this chapter:

"Eligible resident" means an individual who has been legally domiciled in this state for a period of 60 days. For purposes of this chapter, legal domicile is established by living in this state and obtaining an Iowa motor vehicle operator's license, registering to vote in Iowa, or filing an Iowa income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state for a period of 60 days. A person with a developmental disability or another disability which prevents the person from obtaining an Iowa motor vehicle operator's license, registering to vote in Iowa, or filing an Iowa income tax return, is legally domiciled in this state by living in the state for 60 days.

"Insured group health plan" as that term is referenced in Iowa Code section 513C.3 includes a health benefit plan offered directly through an employer with two or more employees and a plan offered through an employer with two or more employees under a group discretionary trust or association plan.

"Organized delivery system" means an organized delivery system licensed by the director, pursuant to 641 IAC 201, and will be referred to as an ODS in this chapter.

"Risk characteristic" means the health status, claims experience or any similar characteristic related to the health status or experience of an individual under a health benefit plan.

"Risk load" means the percentage above the applicable base premium rate that is charged by a carrier or ODS to an individual to reflect the risk characteristics of such individual.

Other terms shall be defined pursuant to 1995 Iowa Acts, chapter 5.

191—75.3(513C) Applicability and scope.

75.3(1) Except as otherwise specifically provided, this chapter shall apply to any individual health benefit plan applied for on or after April 1, 1996.

75.3(2) Iowa Code chapter 513C and this chapter shall apply to an individual health benefit plan provided to an eligible individual.

75.3(3) An entity that is not operating as an individual health benefit plan carrier or ODS in this state shall not become subject to the provisions of the Act and this rule solely because an individual that was issued a health benefit plan in another state by that entity becomes a resident of this state.

75.3(4) This chapter shall not apply to health insurance policies or certificates that are subject to Iowa Code chapter 513B.

75.3(5) Except for basic or standard health benefit plans, nothing in Iowa Code chapter 513C or this chapter is applicable to underwriting practices, substandard ratings, or the addition of waivers or riders to policies or certificates.

191—75.4(513C) Establishment of blocks of business. A carrier or ODS shall file with the commissioner the following information with respect to each established block of business, as defined in Iowa Code section 513C.3.

1. A description of each criterion employed by the carrier or ODS for determining membership in the block of business;

2. A statement describing the justification for establishing the block as a separate block of business;

3. A statement disclosing which, if any, health benefit plans are currently available for purchase in the block and any significant limitations related to the purchase of such plans.

191—75.5(513C) Transition for assumptions of business from another carrier or ODS.

75.5(1) Transfer or assumption of insurance obligation.

a. A carrier or ODS shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering a block of business in this state unless the transaction has been approved by the commissioner of the state of domicile of the ceding carrier or ODS.

b. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk or one or more blocks of business from another carrier or ODS shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of Iowa Code chapter 513C and this chapter.

c. The filing required under paragraph 75.5(1)*"b"* shall:

(1) Describe the block of business, including any eligibility requirements, of the ceding carrier or ODS from which the health benefit plans will be ceded;

(2) Describe whether the assuming carrier or ODS will maintain the assumed health benefit plans as a separate block of business, pursuant to 75.5(3), or will incorporate them into an existing block of business, pursuant to 75.5(4). If the assumed health benefit plans will be incorporated into an existing block of business, the filing shall describe the block of business of the assuming carrier into which the health benefit plans will be incorporated;

(3) Describe whether the health benefit plans being assumed are currently available for purchase by individuals;

(4) Describe the potential effect of the assumption on the benefits provided by the health benefit plans to be assumed;

(5) Describe the potential effect of the assumption on the premiums for the health benefit plans to be assumed;

(6) Describe any other potential material effects of the assumption on the coverage provided to the individuals covered by the health benefit plans to be assumed; and

(7) Include any other information required by the commissioner.

d. A carrier or ODS required to make a filing under 75.5(1)*"b"* shall also make an informational filing with the commissioner of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under 75.5(1)*"b"* and shall include at least the information specified in 75.5(1)*"c"*(1) for the individual health benefit plans in that state.

e. A carrier or ODS shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless it complies with the following provisions:

(1) The carrier or ODS has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in 75.5(1)*"c"* for the health benefit plans covering individuals in this state.

(2) If the assumption of a block of business would result in the assuming carrier or ODS being out of compliance with the limitations related to premium rates contained in Iowa Code section 513C.5, the assuming carrier shall make a filing with the commissioner pursuant to section 513C.5 seeking suspension of the application of section 513C.5.

(3) An assuming carrier or ODS seeking suspension of the application of Iowa Code section 513C.5 shall not complete the assumption of health benefit plans covering individuals unless the commissioner grants the suspension requested pursuant to 75.5(1)*"e"*(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of Iowa Code section 513C.5 shall, with respect to an assumed block of business, be for no more than 15

months and, with respect to each individual, last only until the anniversary date of such individual's coverage. With respect to an individual this period may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the block of business.

75.5(2) Except as provided in subrule 75.5(1), a carrier or ODS shall not cede or assume the entire insurance obligation or risk for a health benefit plan, other than reinsurance, unless the carrier cedes to the assuming carrier the entire block of business that includes such health benefit plan, unless otherwise approved by the commissioner.

75.5(3) The commissioner may approve a longer period of transition upon application of a carrier or ODS. The application shall be made within 60 days after the date of assumption of the block of business and shall clearly state the justification for a longer transition period.

75.5(4) Nothing in this rule or in Iowa Code chapter 513C is intended to:

a. Reduce or diminish any legal or contractual obligation or requirements, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier or ODS related to the transaction;

b. Authorize a carrier or ODS that is not admitted to transact the business of insurance in this state to offer health benefit plans in this state; or

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

191—75.6(513C) Restrictions relating to premium rates.

75.6(1) As provided by Iowa Code section 513C.5, each carrier must limit differences in premium due to such factors as experience and duration to the composite effect of 20 percent, 30 percent, and 30 percent. Allocation of cost differences due to experience and duration among the categories outlined in Iowa Code section 513C.5 may be determined by each carrier.

75.6(2) Nothing in this rule shall require rates be filed absent any other statutory requirements.

191—75.7(513C) Availability of coverage.

75.7(1) Except as provided in Iowa Code section 513C.7, the choice between the basic and standard health benefit plans may not be limited, restricted or conditioned upon the risk characteristics of the individuals or their dependents.

75.7(2) Insurers shall not require eligible family members to accept a basic or standard health benefit plan covering all family members. Those family members who qualify for an underwritten plan may be issued separate coverage from those who do not qualify for the underwritten plan but are eligible for guaranteed issue of the basic or standard plan.

75.7(3) Qualifying previous coverage for a newborn shall be the greater of the period or periods of qualifying previous coverage established by either of the newborn's parents prior to the date of birth.

75.7(4) Benefits paid under a basic or standard health benefit plan shall not duplicate benefits paid under any other health insurance coverage. Other coverage means benefits paid for hospital, surgical or other medical care or expenses for a covered person by any of the following:

a. Insurance plan or policy; or

b. Health benefit plan; or

c. Welfare plan; or

d. Prepayment plan; or

e. Hospital service corporation plan or policy; or

f. Medicare;

whether provided on an individual, family, or group basis or through an employer, union or association. If such other coverage is on a provision of service basis, the amount of benefits will be the amount that the services provided would have cost without such other coverage.

191—75.8(513C) Disclosure of information.

75.8(1) General rules. In connection with the offering for sale of a health benefit plan to individuals, each carrier and ODS shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

a. The extent to which premium rates for a specified individual are established or adjusted in part based upon the actual or expected variation in claims costs or the actual or expected variation in health conditions of the individual and the individual's dependents, if any.

b. The provisions of such plan concerning the carrier's and ODS's ability to change premium rates and the factors, other than claim experience, which affect changes in premium rates.

c. The provisions of such plan relating to the renewability of policies and contracts.

d. The provisions of such plan relating to the effect of any preexisting condition provision. The expression "preexisting conditions" shall not be used unless appropriately defined in the policy or contract.

e. The availability, upon request, of descriptive information about the benefits and premiums available under individual health benefit plans offered by the carrier and ODS for which the individual is qualified. For purposes of Iowa Code section 513C.7, carriers and ODSs will be permitted to exclude from disclosure of plans those plans within the following categories:

(1) Plans distributed through a separate marketing channel.

(2) Plans offered through a membership association.

(3) Plans offered through a trust in which membership is otherwise limited.

(4) Other plans as reviewed and approved by the commissioner or director.

75.8(2) Information shall be provided under this rule in a manner determined to be understandable by the average individual and shall be accurate and sufficiently comprehensive to reasonably inform individuals of their rights and obligations under the plan.

Nothing in this rule supersedes the requirements for outlines of coverage for individual health insurance policies under IAC 191—36.7(514D).

191—75.9(513C) Standards to ensure fair marketing.

75.9(1) A carrier or ODS shall make available at least one basic and one standard health benefit plan to eligible individuals in this state.

75.9(2) The written information described in this subrule may be provided directly to the individual or delivered through an authorized producer:

a. A carrier or ODS shall not apply more stringent requirements related to the application process for the basic and standard health benefit plans than applied for other health benefit plans offered by the carrier or ODS.

b. A carrier or ODS shall supply a price quote for basic or standard plans to an eligible individual upon request.

c. If a carrier or ODS denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and state with specificity the reasons for the denial subject to any restrictions related to confidentiality of medical information. The denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the carrier or ODS and may be combined with the notification requirements of Iowa Code chapter 514E. The explanation shall include the following information about the basic and standard benefit plans:

(1) A general description of the benefits and policy provisions contained in each plan;

(2) A price quote for each plan; and

(3) Information describing eligibility and how an eligible individual may enroll in such plans.

75.9(3) The carrier or ODS shall not require an individual to join or contribute to any association or group as a condition of being accepted for coverage except, if membership in an association or other group is a requirement for accepting an individual into a particular health benefit plan, a carrier or ODS may apply such requirement.

75.9(4) A carrier or ODS may not require as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

75.9(5) Carriers and ODSs offering individual or group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513C.

191—75.10(513C) Basic health benefit plan and standard health benefit plan policy forms.

75.10(1) The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in the rules and table.

75.10(2) Termination of pregnancy is to be covered when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard plan.

75.10(3) A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license.

75.10(4) Prescription oral contraceptives and contraceptive devices that are approved by the United States Food and Drug Administration are to be covered in both policy forms.

75.10(5) The division of insurance and the department of health have available "safe harbor" policy forms for the basic and standard health benefit plans required pursuant to Iowa Code chapter 513C.

Iowa Individual Products

Hospital Services	MANDATED INDEMNITY/ODS				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient Outpatient	60%	80%	80%	60%	60% $400/admit	80% $200/admit
Prostheses	60%	80%	80%	60%	60%	80%
DME—including medical supplies	60%	80%	80%	60%	60%	80%
Ambulance—Emergency	60%	80%	80%	60%	60%	80%
Hospice	60%	80%	80%	60%	60%	80%
Home Health and Physician House Calls	60%	80%	80%	60%	60%	80%

Alcoholism Substance Abuse	MANDATED INDEMNITY/ODS				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1)	60%(1)	—	80% ($50 max. eligible fee)

Mental Health	MANDATED INDEMNITY/ODS				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1) ($50 max. eligible fee)	60%(1) ($50 max. eligible fee)	—	80% ($50 max. eligible fee)

(1)$50,000 Lifetime Max.

Iowa Individual Products

General	MANDATED INDEMNITY/ODS				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Calendar year deductibles (S/F)	$1,500 x 3	$1,000 x 3	$1,000 x 3	$1,000 x 3	—	—
E.R. Copayment	—	—	—	—	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	80%	60%	60%	80%
Annual out-of-pocket max. (1)	$4,800/ $14,400	$2,000/ $4,000	$2,000/ $4,000	$3,000/ $6,000	$4,000/ $8,000	$2,000/ $4,000
Lifetime Maximum	$250,000	$1,000,000	$1,000,000	$1,000,000	$250,000	$1,000,000
Pre-existing	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)
Rx	60%	80%	80%	60%	Copayment of > $30 or 25%	Copayment of > $20 or 25%
Transplants	None	80%	80%	80%	None	80%

(1)Excludes deductibles and copays

Physician Services	MANDATED INDEMNITY/ODS				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Office visits including wellness	60%	80%	$20 copay 100%	$40 copay 60%	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	80%	60%	60%	80%
Inpatient	60%	80%	80%	60%	60%	80%
Outpatient	60%	80%	80%	60%	60%	80%

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

75.10(6) Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions;
7. For any illness or injury suffered as a result of any act of war, declared or undeclared, or military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;

9. For which no expense is incurred;

10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;

11. Rendered by a provider that is a member of the insured's immediate family;

12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;

13. Incurred after the date of termination of the insured's coverage;

14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;

16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;

17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;

18. For custodial care, domiciliary care or rest cures;

19. For treatment in a facility, or part of a facility, that is mainly a place for:

- Rest;
- Convalescence;
- Custodial care;
- Aged;
- Care or treatment of alcoholism or drug addiction;
- Rehabilitation; or
- Training, schooling or occupational therapy;

20. For screening examinations including X-ray examinations made without film;

21. For sterilization or reversal of sterilizations, or both;

22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;

23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;

24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);

25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;

26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;

28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;

29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;

30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;

31. For travel whether or not recommended by a physician;

32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;

33. For maternity care except for complications of pregnancy which is covered as any other illness;

34. For services to the extent that those services are covered by Medicare;

35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);

36. For or related to the transplantation of animal or artificial organs or tissues;

37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;

38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;

39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;

40. For the purchase of wigs or cranial prosthesis;

41. For weekend admission charges, except for emergencies;

42. For orthomolecular therapy including nutrients, vitamins and food supplements;

43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

191—75.11(513C) Maternity benefit rider. Every individual insurance carrier and ODS shall offer an optional maternity benefit rider for the basic and standard health benefit plans providing benefits, as any other illness, for a pregnancy and delivery without complications with a 12-month waiting period. Credit toward meeting the waiting period shall be given for prior coverage of a pregnancy without complications provided there was no more than a 63-day break in coverage. A maternity rider offered under this rule shall only be offered when the basic or standard plan is initially purchased. Premiums for the rider shall be calculated based upon generally accepted actuarial principles and shall not be subject to the premium restrictions in Iowa Code subsection 513C.10(6). The earned premiums and paid losses associated with the rider shall not be considered by the Iowa Individual Health Benefit Reinsurance Association for purposes of Iowa Code section 513C.10.

191—75.12(513C) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier or ODS offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers and ODSs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—75.13(514C) Treatment options.

75.13(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

75.13(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—75.14(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall

be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

75.14(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

75.14(2) The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

75.14(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the carrier. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and provider that they may register a complaint with the commissioner of insurance.

191—75.15(514C) Provider access. A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—75.16(514C) Diabetic coverage. All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.14.

These rules are intended to implement Iowa Code chapters 513C and 514C and 1997 Iowa Acts, House File 701; 1995 Iowa Acts, chapter 204, section 14; 1996 Iowa Acts, chapter 1219, section 52; and 1999 Iowa Acts, Senate File 276.

191—75.17(513C) Reconstructive surgery.

75.17(1) A carrier or organized delivery system that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

75.17(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

75.17(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

75.17(4) A carrier or organized delivery system shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier or organized delivery system shall not penalize, reduce

or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

191—75.18(514C) Contraceptive coverage.

75.18(1) A carrier or organized delivery system that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

75.18(2) A carrier or organized delivery system is not required to offer benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

75.18(3) A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

75.18(4) A carrier or organized delivery system shall make available benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

75.18(5) If a carrier or organized delivery system does not provide benefits for a routine physical examination, the carrier or organized delivery system is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement 2000 Iowa Acts, Senate File 2126.

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CHAPTER 76
EXTERNAL REVIEW

191—76.1(514J) Purpose. This chapter is intended to implement Iowa Code chapter 514J to provide a uniform process for enrollees of carriers and organized delivery systems providing health insurance coverage to request an external review of a coverage decision based upon medical necessity. Carriers defined in Iowa Code section 514J.2(1) and organized delivery systems as defined in Iowa Code section 514J.2(6) are subject to these rules.

191—76.2(514J) Applicable law. The rules contained in this chapter shall apply to any sickness or accident plan and any plan of health insurance, health care benefits or health care services delivered or issued for delivery in this state by an insurance company, a health maintenance organization, or a nonprofit health service corporation, and any plan established pursuant to Iowa Code chapter 509A.

191—76.3(514J) Notice of coverage decision and content. The notice required under Iowa Code chapter 514J shall contain the following information:

1. The enrollee was covered by the carrier at the time the service or treatment was proposed;
2. The enrollee has been denied coverage based on a determination by the carrier that the proposed service or treatment does not meet the definition of medical necessity;
3. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee has exhausted all internal appeal mechanisms provided under the carrier's evidence of coverage; and
4. Information on how the enrollee or the enrollee's treating health care provider can request an external review. The information provided shall specify the following:

- The enrollee or the enrollee's treating health care provider must send the request for an external review within 60 days of receipt of the coverage decision from the carrier;
- The request shall be made to the Division of Insurance, 330 Maple Street, Des Moines, Iowa 50319;
- A copy of the carrier's coverage decision shall accompany the written request for an external review;
- A $25 filing fee is required unless the enrollee is requesting that the fee be waived. The check should be made payable to the Insurance Division. If a waiver is requested, the request shall include an explanation of why the enrollee is requesting that the fee be waived.

191—76.4(514J) External review request.

76.4(1) The enrollee shall send a copy of the carrier's or organized delivery system's written notice containing the coverage decision with the enrollee's request for an external review to the insurance commissioner within 60 days of the receipt of the coverage decision. The notice shall be sent to the commissioner at the Insurance Division, 330 Maple Street, Des Moines, Iowa 50319.

76.4(2) A $25 filing fee shall be enclosed with the external review request. The commissioner may waive the fee for good cause.

191—76.5(514J) Certification process.

76.5(1) The commissioner shall fax the certification decision to the carrier or organized delivery system and the enrollee or the enrollee's treating health care provider acting on behalf of the enrollee within the two-day period specified in Iowa Code section 514J.5(1).

76.5(2) The commissioner has two business days to rule on a carrier's or organized delivery system's contest of the commissioner's certification decision. The commissioner shall provide a written notice of the determination by fax within the two-day period to the carrier or organized delivery system and the enrollee or the enrollee's treating health care provider acting on behalf of the enrollee.

191—76.6(514J) Expedited review.

76.6(1) The enrollee's treating health care provider shall directly contact the carrier or organized delivery system for an expedited review if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

76.6(2) The enrollee's treating health care provider and the carrier or organized delivery system shall select within 72 hours an independent review entity to conduct the external review. In the event that the enrollee's treating health care provider and the carrier or organized delivery system cannot reach an agreement upon the selection of an independent review entity, the enrollee's treating health care provider shall notify the commissioner who shall select an independent review entity.

76.6(3) The carrier or organized delivery system and the enrollee's treating health care provider shall provide any additional medical information to the review entity.

76.6(4) The enrollee's treating health care provider shall notify the commissioner of the expedited review request following the agreement in subrule 76.6(2).

76.6(5) In the event the carrier or organized delivery system does not find that a delay would pose an imminent or serious threat to the enrollee, the enrollee's treating health care provider may ask the commissioner to immediately review the request for certification as an expedited review.

76.6(6) A review by the commissioner under subrule 76.6(5) shall stay the 72-hour expedited review time period.

191—76.7(514J) Decision notification. The independent review entity shall immediately notify the carrier or organized delivery system, enrollee or enrollee's treating health care provider, and insurance division of the external appeal decision. The initial notification shall be delivered by telephone or fax transmission, and a hard copy of the notice may be delivered by regular mail.

191—76.8(514J) Carrier information.

76.8(1) Each carrier or organized delivery system shall provide to the commissioner the name or title, telephone and fax numbers and E-mail address of an individual who shall be the carrier's or organized delivery system's contact person for external review procedures. Any changes in personnel or communication numbers shall be immediately sent to the commissioner.

76.8(2) Each carrier or organized delivery system shall provide to the commissioner a detailed description of the process the carrier or organized delivery system has in place to ensure compliance with the requirements found in this chapter and in Iowa Code chapter 514J. The description shall include:

a. An explanation of how the carrier or organized delivery system determines when a person has qualified for external review and should receive a notice from the carrier or organized delivery system, and

b. A copy of the notice sent to persons who fall within the scope of the law.

Information required by this subrule shall be filed by March 1, 2002, and thereafter biennially on March 1.

191—76.9(514J) Certification of independent review entity.

76.9(1) The following minimum standards are required for certification as an independent review entity:

a. The individual must hold a current unrestricted license to practice a health care profession in the United States.

b. A health care professional who is a medical physician shall also hold a certification by a recognized American medical specialty board.

c. A health care professional who is not a medical physician shall also hold a current certification by the professional's respective licensing or specialty board if applicable.

d. The applicant must attest that reviewers have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending

by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

e. The applicant shall provide a description of the qualifications of the reviewers retained to conduct external reviews of coverage decisions including the reviewers' current and past employment histories and practice affiliations.

f. The applicant shall provide a description of the procedures employed to ensure that reviewers conducting external reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; and knowledgeable about the health care service which is the subject of the external review.

g. The applicant shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

h. The applicant shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review.

i. The applicant shall provide a description of the policies and procedures employed to protect confidentiality of individual medical and treatment records in accordance with applicable state and federal law.

j. The applicant shall provide a description of the quality assurance program established by the independent review entity.

k. The applicant shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the applicant, and the nature and extent of any such ownership or control.

l. The applicant shall provide the names and résumés of all directors, officers, and executives of the independent review entity.

m. The applicant shall provide a description of the fees to be charged by the review entity for external reviews.

n. The applicant shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

76.9(2) The independent review entity shall develop written policies and procedures governing all aspects of the external review process including, at a minimum, the following:

a. Procedures to ensure that external reviews are conducted within the time frames specified in this chapter and Iowa Code chapter 514J and that any required notices are provided in a timely manner.

b. Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the health care service which is the subject of the coverage decision under external review. The reviewers shall be experts in the treatment of the medical condition under review.

c. Procedures to ensure that the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, is notified in writing of the enrollee's right to object to the independent review entity selected by the carrier or organized delivery system or the person selected as the reviewer by the independent review entity by notifying the commissioner at the Insurance Division, 330 Maple Street, Des Moines, Iowa 50319, within ten days of the mailing of the notice by the independent review entity.

d. Procedures to ensure the confidentiality of medical and health treatment records and review materials.

e. Procedures to ensure adherence to the requirements of this chapter and Iowa Code chapter 514J by any contractor, subcontractor, subvendor, agent or employee affiliated with the certified independent review entity.

76.9(3) The independent review entity shall establish a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in external reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.

76.9(4) The independent review entity shall establish a toll-free telephone service to receive information relating to external reviews pursuant to this chapter and Iowa Code chapter 514J. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.

76.9(5) No independent review entity, officer, director, employee, or reviewer employed or engaged to conduct external reviews shall have any material professional affiliation or material financial affiliation with a health plan for which it is conducting a review.

76.9(6) The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the external review process established under Iowa Code chapter 514J.

76.9(7) Applications shall be submitted in duplicate to the Commissioner of Insurance, 330 Maple Street, Des Moines, Iowa 50319. Applications must be submitted in full to be considered. All applicants will be notified of the certification decision. A list of certified independent review entities shall be maintained at the division of insurance and shall be available through the division's Web site.

These rules are intended to implement Iowa Code chapter 514J as amended by 2001 Iowa Acts, Senate File 500.

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CHAPTER 77
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS*

191—77.1(507A) Certificate of registration. A person shall not establish or maintain a self-insured employee welfare benefit plan which is a multiple employer welfare arrangement (hereinafter MEWA) in this state unless the MEWA obtains and maintains a certificate of registration pursuant to this rule.

This rule is intended to implement Iowa Code section 507A.4.

191—77.2(507A) Application for certificate of registration.

77.2(1) A person wishing to obtain a certificate of registration pursuant to this chapter shall register and submit a plan of operation with the commissioner. This application and plan of operation shall include the following:

a. A business plan including a copy of all contracts or other instruments which the MEWA proposes to make with or sell to its members, a copy of its plan description and the printed matter to be used in the solicitation of members.

b. Copies of all articles, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the MEWA.

c. A current list of all members of the employer group or association sponsoring the MEWA and a description of the relationship among the employers which serves as the basis for the formation of the association or employer group.

d. A description of the activities of the association or group of employers on behalf of its members other than the sponsorship of the MEWA.

e. Current financial statements of the MEWA which shall include at a minimum balance sheets, income statement, cash flow statement and detailed listing of assets.

f. An actuarial opinion prepared, signed, and dated by a person who is a member of the American Academy of Actuaries which states that appropriate loss and loss adjustment reserves have been established, that adequate premiums are being charged, and that the association is operating in accordance with sound actuarial principles and in conformance with this rule.

g. A statement from an authorized representative of the applicant which certifies all of the following:

(1) The MEWA is administered by an authorized insurer or an authorized third-party administrator.

(2) The MEWA has been in existence and has provided health benefits for at least five years prior to July 1, 1997.

(3) The MEWA was established by a trade, industry, or professional association of employers that has a constitution or bylaws, and has been organized and maintained in good faith for at least ten continuous years prior to July 1, 1997.

(4) The association or group of employers sponsoring the MEWA is engaged in substantial activity for its members other than sponsorship of an employer welfare benefit plan.

(5) The association is a nonprofit entity organized or authorized to do business under applicable Iowa law.

h. A certificate from the applicant that, to the best of its knowledge and belief, the MEWA is in compliance with all applicable provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

i. A mechanism approved by the commissioner to ensure that claims shall be paid in the event a member of the MEWA is unable to comply with the MEWA's contribution requirements.

j. A copy of the most recent Form M-1 filed by the MEWA with the U.S. Department of Labor, Pension and Welfare Benefits Administration.

k. Any additional information requested by the commissioner.

*Effective date of Chapter 77 delayed 70 days from 3/28/01 by the Administrative Rules Review Committee at its meeting held March 9, 2001.

77.2(2) The commissioner shall examine the application and supporting documents submitted by the applicant and shall have the power to conduct any investigation which the commissioner may deem necessary and to examine under oath any persons interested in or connected with the MEWA.

77.2(3) Within a reasonable time, the commissioner shall issue to the MEWA a certificate upon finding that the applicant MEWA has met all requirements, or the commissioner shall notify the applicant setting forth reasons for a denial upon finding that the applicant MEWA does not meet all the requirements. An unsuccessful applicant may file a new application for certificate of registration at any time.

77.2(4) Modifications to the plan of operation including but not limited to amendments to articles of incorporation and bylaws shall be submitted for prior approval to the commissioner.

This rule is intended to implement Iowa Code section 507A.4.

191—77.3(507A) Financial requirements.

77.3(1) *Surplus.*

a. Unless otherwise provided below or pursuant to the discretion of the commissioner, each MEWA shall deposit with an organization or trustee meeting the requirements of 191—32.4(508) cash, securities or any combination of these that is acceptable in the amount set forth below. In addition to the requirements set forth below, the commissioner may increase the amount required to be deposited based on the commissioner's written determination that such an increase is necessary to adequately secure any potential liability of the MEWA to its enrollees, subject to Iowa Code chapter 17A proceedings.

b. The surplus requirement for a MEWA shall be the greater of:

(1) $500,000; or

(2) An amount equal to 10 percent of the written premium as of the previous December 31.

77.3(2) *Reserves and stop-loss coverage.*

a. MEWAs shall have at all times aggregate excess stop-loss coverage providing the MEWA with coverage with an attachment point which is not greater than 120 percent of actuarially projected losses on a calendar-year basis.

b. MEWAs shall establish and maintain specific stop-loss coverage providing the MEWA with coverage with an attachment point which is not greater than 5 percent of annual expected claims for purposes of this subrule and shall provide for adjustments in the amount of that percentage as may be necessary to carry out the purposes of this subrule as determined by sound actuarial principles.

c. MEWAs shall establish and maintain appropriate loss and loss adjustment reserves determined by sound actuarial principles.

d. Premiums shall be set to fund at least 100 percent of the MEWA's actuarially projected losses plus all other costs of the MEWA.

e. All coverage obtained pursuant to this subrule shall contain a provision allowing for at least 90 days' notice to the commissioner upon cancellation or nonrenewal of the contract.

f. No contract or policy of per occurrence or aggregate excess insurance shall be recognized in considering the ability of an applicant to fulfill its financial obligations under this subrule, unless such contract or policy is issued by a company that is:

(1) Licensed to transact business in this state; or

(2) Authorized to do business in Iowa as an accredited reinsurer.

77.3(3) *Filing requirements.* The following reports shall be filed with the commissioner.

a. Annual report. A MEWA shall annually, on or before the first day of March, file with the commissioner of insurance a report which has been verified by at least two of its principal officers and which covers the preceding calendar year. The report shall be on the form designated by the commissioner. The report shall be completed using statutory accounting practices and shall include information required by the commissioner. The commissioner may request additional reports and information from a MEWA as deemed necessary.

b. Independent actuarial report. A MEWA shall annually, on or before the first day of March, file with the commissioner of insurance an independent actuarial opinion prepared in conformance with this

rule. The commissioner may conduct an independent actuarial review of a MEWA in addition to the actuarial opinion required by this rule. The cost of any actuarial review shall be paid by the MEWA.

c. Certificate of compliance. A MEWA shall annually, on or before the first day of March, file a certificate of compliance, which shall be signed and dated by the appropriate official representing the MEWA and shall certify the following:

(1) That the plan meets the requirements of this rule and the applicable provisions of the Iowa statutes and regulations;

(2) That an independent actuarial opinion has been attached to the certificate which attests to the adequacy of reserves, rates, and the financial condition of the plan. The actuarial opinion must include, but is not limited to, a brief commentary about the adequacy of the reserves, rates, and other financial condition of the plan, a test of the prior year's claim reserve, a brief description of how the reserves were calculated, and whether or not the plan is able to cover all reasonably anticipated expenses. The actuarial opinion shall be prepared, signed, and dated by a person who is a member of the American Academy of Actuaries;

(3) That a written complaint procedure has been implemented. The certificate shall also list the number of complaints filed by participants under the written complaint procedure, and the percentage of participants filing written complaints in the prior calendar year; and

(4) That the MEWA has contracted with an insurer authorized to do business in this state or with a third-party administrator who holds a current certificate of registration issued by the commissioner pursuant to Iowa Code section 510.21.

This rule is intended to implement Iowa Code section 507A.4.

191—77.4(507A) Policy or contract. All contracts issued by a MEWA shall comply with the following within 12 months of March 28, 2001:

77.4(1) Notice to purchasers. Every MEWA application for insurance and every policy and certificate issued by a MEWA shall contain in ten-point type on the front page the following notice prominently displayed:

NOTICE
This policy is issued by a multiple employer welfare association (MEWA). MEWAs are not subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your MEWA.

77.4(2) MEWAs must offer on a guarantee-issue basis health benefits to all individuals who qualify as members or enrollees of the association.

77.4(3) Rescinded IAB 9/19/01, effective 10/24/01.

77.4(4) MEWAs shall offer only medical, dental, optical, surgical, hospital, accident and sickness, prescription, life insurance, or disability benefits. A MEWA that offers life insurance benefits shall comply with all applicable provisions of the Iowa Code relating to life insurance and life insurance companies.

77.4(5) All contracts or policies issued by a MEWA shall conform to all the provisions of P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996, including but not limited to guaranteed issue of all products, preexisting condition limitations, renewability, and portability provisions as well as the issuance of prior coverage certificates to enrollees no longer eligible for plan coverage.

This rule is intended to implement Iowa Code section 507A.4.

191—77.5(507A) Disclosure. The following disclosure shall be made to each employer member of the MEWA: The benefits and coverages described herein are provided through a self-insured trust fund

established and funded in full or in part by a group of employers. It is not a licensed insurance company and it is not protected by a guaranty fund in the event of insolvency.

This rule is intended to implement Iowa Code section 507A.4.

191—77.6(507A) Filing fee. A filing fee of $100 shall accompany each application for registration as a multiple employer welfare MEWA.

This rule is intended to implement Iowa Code section 507A.4.

191—77.7(507A) Agreements and management contracts. Any agreement between the MEWA and any administrator, service company, or other entity shall be made available for review in the office of the commissioner upon request by the commissioner.

This rule is intended to implement Iowa Code section 507A.4.

191—77.8(507A) Examination.

77.8(1) Each MEWA shall be subject to examination by the commissioner in accordance with Iowa Code chapter 507. Chapter 507 shall govern all aspects of the examination.

77.8(2) The commissioner may make an examination of a MEWA as often as the commissioner considers it necessary, but not less frequently than once every five years. The expenses of the examination shall be assessed against the MEWA being examined in a manner in which expenses of examinations are assessed against an insurance company under Iowa Code chapter 507.

This rule is intended to implement Iowa Code section 507A.4.

191—77.9(507A) Trade practices. MEWAs are subject to applicable provisions of the unfair trade practices Act, Iowa Code chapter 507B.

This rule is intended to implement Iowa Code section 507A.4.

191—77.10(507A) Insolvency. The provisions of Iowa Code chapter 507C shall apply to MEWAs which shall be considered insurers for purposes of that chapter. However, a MEWA shall not be subject to Iowa Code chapter 508C.

This rule is intended to implement Iowa Code section 507A.4.

191—77.11(507A) Suspension or revocation of certificate. The commissioner may sanction a MEWA or suspend or revoke any certificate issued to a MEWA upon any of the following grounds:

1. Failure to comply with any provision of these rules or any applicable provision of the Iowa Code;
2. Failure to comply with any lawful order of the commissioner;
3. Failure to promptly pay lawful benefit claims;
4. Committing an unfair or deceptive act or practice;
5. Deterioration of financial condition adversely affecting the MEWA's ability to pay claims;
6. A finding that the application or any necessary forms that have been filed with the division contain fraudulent information or omissions;
7. A finding that the MEWA or its administrator has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys that belong to a member, a participant, or a person otherwise entitled thereto and that have been entrusted to the MEWA or its administrator in its fiduciary capacity;
8. Rescinded IAB 9/19/01, effective 10/24/01.

This rule is intended to implement Iowa Code section 507A.4.

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CHAPTER 78
UNIFORM PRESCRIPTION DRUG INFORMATION CARD

191—78.1(514L) Purpose. The purpose of this chapter is to implement the use of a uniform prescription drug information card or other technology by the providers of third-party payment or prepayment of prescription drug expenses, by the providers' contractors or agents and pharmacy benefit managers, and by administrators of the providers and payors. The purpose of the uniform prescription drug information card or other technology is to benefit patients, insurers, pharmacy benefit managers and pharmacists through enhanced patient convenience and processing of claims for prescription benefits, decreased calls to help desks due to missing or incorrect card information, and improved delivery of prescription benefit services to consumers.

191—78.2(514L) Definitions.

"Administrator" or *"administrator of the payor"* means the claims administrator or administrators to which claims for prescription drug benefits are submitted, processed and adjudicated, and includes pharmacy benefit managers, and excludes administrators for self-funded employer-sponsored health benefit plans qualified under the federal Employee Retirement Income Security Act of 1974.

"BIN number," "IIN/BIN number," "BIN," or *"RxBIN"* means the ANSI-assigned issuer identification number, or IIN, which was formerly known as the "bank identification number" or "BIN," and which is identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide as the "BIN number." The "Rx" prefix is not required if the same BIN number is used for pharmacy and medical claims submission.

"Card" or *"card or other technology for claims processing"* means a card or other technology that is issued to insureds, enrollees, and covered individuals. Insureds, enrollees, and covered individuals provide the card to pharmacies to receive prescription drug benefits. Pharmacies use the information, required by Iowa Code chapter 514L to be on the card, for prescription drug claims submission, processing and adjudication with providers, administrators, pharmacy benefit managers or similar entities.

"Cardholder ID" means the cardholder's unique identification number that is issued by the provider to the insured, enrollee, or covered individual, and which is identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide.

"Cardholder name" means the cardholder's first name, middle initial and last name.

"Card issuer identifier number" means the number identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide as the international identifier for the United States of America, which has not yet been enumerated and may remain blank on cards until such number is determined.

"Card issuer's name and logo" means the name and identifying mark of the entity issuing the card or other technology, identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide.

"Consistent with the guide" means that the information and data elements on the card shall conform to the standards set forth in the most recent release of the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide, except that the address of the pharmacy benefit manager may be excluded and the information and data elements may be placed at different locations on the card as reasonably necessary to accommodate space and logistical needs.

"Group ID number," "Grp," or *"RxGrp"* means the group identification number or group ID number as identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The "Rx" prefix is not required if the same group number is used for pharmacy and medical claims submission.

"Guide" or *"National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide"* means the most recent document issued by the National Council for Prescription Drug Programs.

"Pharmacy benefit manager" means an entity that receives and processes claims for payment or prepayment for prescription drug expenses from pharmacies and that may issue cards or other technology for prescription claims processing.

"Processor control number," "PCN," or *"RxPCN"* means the processor control number as identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The "Rx" prefix is not required if the same PCN number is used for pharmacy and medical claims submission.

"Provider of third-party payment or prepayment of prescription drug expenses" or *"provider"* means a provider of an individual or group policy of accident or health insurance or an individual or group hospital or health care service contract issued pursuant to Iowa Code chapter 509, 514 or 514A, a provider of a plan established pursuant to Iowa Code chapter 509A for public employees, a provider of an individual or group health maintenance organization contract issued and regulated under Iowa Code chapter 514B, a provider of an organized delivery system contract regulated under rules adopted by the director of public health, a provider of a preferred provider contract issued pursuant to Iowa Code chapter 514F, a provider of a self-insured multiple employer welfare arrangement, and any other entity providing health insurance or health benefits which provide for payment or prepayment of prescription drug expenses coverage subject to state insurance regulation.

"Substantially consistent with the guide" means that the location of the uniform prescription drug information on the card or other technology shall conform to the standards set forth in the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The information may be placed at different locations on the card as reasonably necessary to accommodate space and logistical needs.

"Uniform prescription drug information" means the requirements set forth in the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide, including the data elements information required on the card, such as the content, format and the location.

191—78.3(514L) Implementation.

78.3(1) Cards or other technology for prescription claims processing issued by providers, administrators, pharmacy benefit managers, and other entities shall contain data elements and other required information that is substantially consistent with the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The location of the data elements and information shall be substantially consistent with the guide, and the cards or other technology shall at a minimum contain the following:

a. The BIN number labeled as "BIN" or "RxBIN."

b. The processor control number labeled as "PCN" or "RxPCN" if required for claims processing.

c. The group identification number labeled as "Grp" or "RxGrp" if required for claims processing.

d. The card issuer's identification number if available.

e. The cardholder's name.

f. The card issuer's name or logo.

g. The help desk name and telephone number for claims submission, processing and other assistance clearly labeled as "Help Desk" or "Pharmacy Service," except that this information may be excluded from the card if the name and telephone number is provided electronically in a readable manner to the pharmacy computer at the time of claims processing and submission.

Notwithstanding the foregoing, nothing in this rule shall be interpreted to preclude the inclusion of additional data elements and information.

78.3(2) If the card or other technology is issued by the provider of third-party payment or prepayment of prescription drug expenses, the provider shall be responsible for issuing the card or other technology in compliance with these rules.

78.3(3) If the card or other technology is not issued by the provider of third-party payment or prepayment of prescription drug expenses and the card or other technology is issued by an administrator, pharmacy benefit manager, or other entity, the provider and entity shall enter into an agreement as to whether the provider or entity shall be responsible for compliance with these rules.

78.3(4) For new insureds, enrollees, or otherwise covered individuals, the provider, administrator, pharmacy benefit manager, or other entity responsible for issuing cards or other technology in compliance with these rules shall issue the cards or other technology no later than 30 days after the insured, enrollee, or covered individual becomes eligible for prescription drug benefits.

78.3(5) The provider, administrator, pharmacy benefit manager, or other entity responsible for issuing cards or other technology shall reissue cards in compliance with these rules at least once per year if the material information required on the cards or other technology under these rules changes. Nothing in these rules shall prevent such entities from issuing cards or other technology more than once per year.

78.3(6) The data elements and information required on the cards or other technology pursuant to these rules shall be printed in a clear and readable form.

78.3(7) Nothing in this rule shall prohibit the provider, administrator, pharmacy benefit manager or any other entity required to comply with these rules from issuing a card or other technology containing a magnetic strip or other technological component or device enabling the electronic transmission of information for prescription claims submission, processing, or adjudication, provided that the information required by these rules is printed on the card or other technology in a clear and readable form.

These rules are intended to implement Iowa Code chapter 514L.

[Filed emergency 8/27/03—published 9/17/03, effective 8/27/03]

CHAPTER 79
Reserved

INSURANCE COVERAGE FOR
PEDIATRIC PREVENTIVE SERVICES

CHAPTER 80
WELL-CHILD CARE

191—80.1(505,514H) Purpose. The purpose of this chapter is to implement Iowa Code section 514H.7A, as amended by 1993 Iowa Acts, House File 236, thereby setting forth those requirements deemed appropriate by the commissioner for the general provision of coverage for benefits for routine well-child care.

191—80.2(505,514H) Applicability and scope. This chapter shall apply to all group accident and sickness insurance, group nonprofit health service plans and prepaid group plans of health maintenance organizations delivered or issued for delivery in this state after March 1, 1993. However, this chapter shall not apply to those basic benefit policies approved under Iowa Code chapter 514H.

191—80.3(505,514H) Effective date. This chapter shall be effective on July 2, 1993, and shall be applicable to all new filings of group accident and sickness insurance, group nonprofit health service plans and prepaid group plans of health maintenance organizations made after that date and all other policies and contracts covered by this chapter delivered or issued for delivery prior to July 2, 1993, upon the date of renewal.

191—80.4(505,514H) Policy definitions. No group accident and sickness insurance, group nonprofit health service plan or prepaid group plan of a health maintenance organization delivered or issued for delivery in this state shall contain definitions respecting the matters set forth unless such definitions comply with the requirements of this rule.

80.4(1) *"Well-child care"* means pediatric preventive services appropriate to the age of a child from birth to age seven as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. The Recommendations may be obtained by contacting the American Academy of Pediatrics at 141 Northwest Point Boulevard, P.O. Box 927, Elk Grove Village, Illinois 60009-0927. Pediatric preventive services shall include, at a minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

80.4(2) *"Developmental assessment"* and *"anticipatory guidance"* mean the services described in the Guidelines for Health Supervision II, published by and obtainable from the American Academy of Pediatrics.

191—80.5(505,514H) Benefit plan.

80.5(1) Every group accident and sickness insurance policy, group nonprofit health service plan or prepaid group plan of a health maintenance organization shall provide benefits for well-child care for any child covered by the policy or contract at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months or two years, three years, four years, five years and six years.

80.5(2) Minimum benefits may be limited to one visit payable to one provider for all services provided at each visit cited in this rule.

80.5(3) Benefits shall be subject to any policy provisions which apply to other services covered by such policy, except as set forth in 80.5(5).

80.5(4) This rule does not apply to disability income, specified disease, Medicare supplement, hospital indemnity, long-term care or trip/travel policies.

80.5(5) The provisions of this benefit will supersede any deductible requirements.

These rules are intended to implement Iowa Code sections 505.8 and 514H.7A.

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[Filed emergency 7/2/93—published 7/21/93, effective 7/2/93]

CHAPTER 81
POSTDELIVERY BENEFITS AND CARE

191—81.1(514C) Purpose. The purpose of this chapter is to implement Iowa Code section 514C.12, thereby setting forth those requirements deemed appropriate by the commissioner for the general provision of coverage for benefits for postdelivery care.

191—81.2(514C) Applicability and scope. This chapter shall apply to all individual or group accident and health insurance, individual or group hospital or health care service contracts issued pursuant to Iowa Code chapter 509, 509A, 514, or 514A, and individual or group health maintenance organization contracts issued and regulated under chapter 514B, which are delivered, amended, or renewed on or after July 1, 1996.

191—81.3(514C) Postdelivery benefits. Every person issuing contracts under the scope of this chapter providing maternity benefits, which are not limited to complications of pregnancy, or newborn care benefits, shall not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician after consultation with the mother and in accordance with the Guidelines for Perinatal Care, Third Edition, 1992, by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which provide that when complications are not present, the postpartum hospital stay ranges from a minimum of 48 hours for a vaginal delivery to a minimum of 96 hours for a Cesarean birth, excluding the day of delivery. In accordance with those guidelines, in the event of a discharge from the hospital prior to the minimum stay established in the guidelines, a postdischarge follow-up visit shall be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician. Copies of this publication may be obtained through the Iowa Insurance Division, Lucas State Office Building, Des Moines, Iowa 50319, telephone (515)281-5705.

These rules are intended to implement Iowa Code section 514C.12.

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CHAPTERS 82 to 89
Reserved

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.

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 90.12(505), 90.13(505) and 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 90.3(505), 90.4(505), and 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 90.12(505), 90.13(505) and 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 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. Is in a form that combines the licensee's notice with other information, 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 public health. 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 90.12(505), 90.13(505), and 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:

- Information a consumer provides to a licensee on an application to obtain an insurance product or service;
- Account balance information and payment history;
- 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;
- 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;
- 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;
- Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and
- 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:

- Publicly available information in government records which includes information in government real estate records and security interest filings.
- Publicly available information from widely distributed media which includes information from a telephone book, a television or radio program, a newspaper or a Web site that is available to the general

public on an unrestricted basis. A Web site 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.

- 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 presented in the following form:

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 that maintains, processes or otherwise is permitted access to customer information through the person's provision of services directly to the licensee.

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 90.13(505) and 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 90.13(505) and 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.

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 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 Web site.

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 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).

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 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.

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.

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.

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 90.8(505).

90.4(4) A licensee is only required to provide the initial privacy notice unless the content of the notice is changed or amended.

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 90.3(505), 90.4(505) and 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 90.13(505) and 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 90.13(505) and 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 90.12(505) and no other exception in rules 90.13(505) and 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 90.13(505) and 90.14(505), the licensee is not required to list those exceptions in the initial or annual privacy notices required by rules 90.3(505) and 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 *"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.

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.

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 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 90.13(505) and 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 90.3(1)*"b"* and 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 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 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 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.

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 Web site, 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 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 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 90.8(505).

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 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 90.12(505, 90.13(505), and 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 90.8(505).

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 Web site 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 Web site to access insurance products and services electronically and agrees to receive notices at the Web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the Web site; 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 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 Web site or a link to another Web site for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the Web site.

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.

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 90.3(505);

b. The licensee has provided to the consumer an opt-out notice as required in rule 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 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 on-line account with a licensee and agrees to receive the notices required in 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 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.

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 90.13(505) and 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 90.13(505) or 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 90.13(505) and 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 90.13(505) or 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 90.13(505) or 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 90.13(505) and 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 90.13(505) and 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 90.13(505) and 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.

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.

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 90.6(505) and 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 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 90.13(505) and 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 90.13(505) and 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.

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 90.6(505) and 90.9(505), and for service providers and joint marketing in rule 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.

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 90.6(505) and 90.9(505), and for service providers and joint marketing in rule 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).

191—90.15(505) Notice through a Web site. If a licensee provides a notice on a Web site, 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 Web site 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.

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 as follows:

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 90.12(505) except as permitted by rule 90.13(505) or 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.

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.

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.

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 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).

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.

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.

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.

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.

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.

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.

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 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.

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.

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.

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.

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.

191—90.41 to **90.50** Reserved.

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 90.14(505), 90.15(505), and 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 90.13(505) and 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 90.12(505), 90.13(505), and 90.14(505), as well as when permitted by the exceptions in rules 90.13(505) and 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 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 90.12(505), 90.13(505), and 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.

These rules are intended to implement Iowa Code section 505.8, subsection 6, and P.L. 106-102.

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CHAPTER 91
2001 CSO MORTALITY TABLE

191—91.1(508) Purpose. The purpose of this chapter is to recognize, permit and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with Iowa Code sections 508.36(3)*"a"*(3)*"c"* and 508.37(6)*"h"*(6) and 191—Chapter 47.

191—91.2(508) Definitions. For purposes of this chapter, the following definitions shall apply:

"2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

"2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

"Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

"Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

191—91.3(508) 2001 CSO Mortality Table.

91.3(1) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this chapter, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2004, and before the date specified in subrule 91.3(2) and to which Iowa Code sections 508.36(3)*"a"*(3)*"c"* and 508.37(6)*"h"*(6) and 191—Chapter 47 are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

91.3(2) Subject to the conditions stated in this chapter, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which Iowa Code sections 508.36(3)*"a"*(3)*"c"* and 508.37(6)*"h"*(6) are applicable.

191—91.4(508) Conditions.

91.4(1) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

a. Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

b. Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Iowa Code section 508.36(10), and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

c. Smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

91.4(2) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.

91.4(3) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option

of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of rule 91.5(508) relative to use of the select and ultimate form.

91.4(4) When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for a company, the actuarial opinion in the annual statement filed with the commissioner shall be based on an asset adequacy analysis as specified in 191—subrule 5.34(6). The commissioner may exempt a company from this requirement if it does business only in this state and no other state.

191—91.5(508) Applicability of the 2001 CSO Mortality Table to 191—Chapter 47, Valuation of Life Insurance Policies.

91.5(1) The 2001 CSO Mortality Table may be used in the application of 191—Chapter 47 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in rule 91.3(508):

a. Subparagraph 47.2(1)*"b"*(2): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

b. Rule 47.3(508) relating to the definition of "contract segmentation method": All calculations are made using the 2001 CSO mortality rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in 91.5(1)*"d."* The value of "qx+k+t-1" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

c. Subrule 47.4(1): The 2001 CSO Mortality Table is the minimum standard for basic reserves.

d. Subrule 47.4(2): The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in subparagraphs 47.4(2)*"c"*(1) to (9). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by rule or necessary to be in compliance with relevant actuarial standards of practice.

e. Subrule 47.5(3): The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

f. Paragraph 47.5(5)*"d"*: The calculations specified in subrule 47.5(5) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

g. Paragraph 47.5(6)*"d"*: The calculations specified in subrule 47.5(6) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

h. Paragraph 47.5(7)*"b"*: The calculations specified in subrule 47.5(7) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

i. Subparagraph 47.6(1)*"a"*(2): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

91.5(2) Nothing in this rule shall be construed to expand the applicability of 191—Chapter 47 to include life insurance policies exempted under 191—subrule 47.2(1).

191—91.6(508) Gender-blended table.

91.6(1) For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subrule.

91.6(2) The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the National Association of Insurance Commissioners in December 2002.

91.6(3) It shall not, in and of itself, be a violation of Iowa Code chapter 507B for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

191—91.7(508) Separability. If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of this chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code sections 508.36 and 508.37.

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CHAPTER 92
UNIVERSAL LIFE INSURANCE

191—92.1(508) Purpose and authority. The purpose of these rules is to supplement existing regulations on life insurance policies in order to accommodate the development and issuance of universal life plans. These rules are authorized by Iowa Code section 505.8 and are intended to implement Iowa Code sections 508.36 and 508.37.

191—92.2(508) Definitions. For purposes of these rules, the following definitions shall apply:

"Cash surrender value" means the net cash surrender value plus any amounts outstanding as policy loans.

"Commissioner" means the insurance commissioner of Iowa.

"Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy.

"Flexible premium universal life insurance policy" means a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance.

"Interest-indexed universal life insurance policy" or *"interest-indexed policy"* means any universal life insurance policy in which the interest credits are linked to an external referent.

"Net cash surrender value" means the maximum amount payable to the policyowner upon surrender.

"Policy value" means the amount to which separately identified interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

"Universal life insurance policy" means a life insurance policy where separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

191—92.3(508) Scope. These rules apply to all individual universal life insurance policies except variable universal life insurance policies.

191—92.4(508) Valuation.

92.4(1) *Requirements.* The minimum valuation standard for universal life insurance policies shall be the commissioners reserve valuation method, as specified in paragraphs *"a"* through *"m"* below for such policies, and the tables and interest rates specified below. The terminal reserve for the basic policy and any benefits and riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and less (D), where:

a. Reserves by the net level premium method shall be equal to $((A) - (B)) \times r$, where (A), (B) and "r" are as defined below;

b. (A) is the present value of all future guaranteed benefits at the date of valuation;

c. (B) is the quantity $PVFB \times (\ddot{a}_{x+t}/\ddot{a}_x)$, where PVFB is the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer;

d. $\ddot{a}x$ and $\ddot{a}_{x+t}$ are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and x+t, respectively, and continuing until the highest attained age at which a premium may be paid under the policy. The letter "x" is defined as the issue age and the letter "t" is defined as the duration of the policy;

e. The guaranteed maturity premium for flexible premium universal life insurance policies shall be that level gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy (otherwise at the highest age in the valuation mortality table) for an amount which is in accordance with the policy structure. The guaranteed maturity premium is calculated at issue based

on all policy guarantees at issue (excluding guarantees linked to an external referent). The guaranteed maturity premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees;

f. The letter "r" is equal to one, unless the policy is a flexible premium policy and the policy value is less than the guaranteed maturity fund, in which case "r" is the ratio of the policy value to the guaranteed maturity fund;

g. The guaranteed maturity fund at any duration is that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue;

h. (C) is the quantity $((a)\text{-}(b)) \times (\ddot{a}_{x+t}/\ddot{a}_x) \times r$, where (a)-(b) is as described in Iowa Code section 508.36(6) for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer;

i. $\ddot{a}x+t$ and $\ddot{a}_x$ are defined in paragraph *"d"* above;

j. (D) is the sum of any additional quantities analogous to (C) which arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of (C) using the maturity date in effect at the time of the change;

k. The guaranteed maturity premium, the guaranteed maturity fund and (B) above shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the descriptions above;

l. Future guaranteed benefits are determined by: (1) projecting the greater of the guaranteed maturity fund and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc. contained in the policy or declared by the insurer; and (2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value;

m. All present values shall be determined using: (1) an interest rate (or rates) specified by Iowa Code section 508.36(3) through (5) for policies issued in the same year; (2) the mortality rates specified by Iowa Code section 508.36(3) and (4) for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose; and (3) any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

92.4(2) *Alternative minimum reserves.*

a. If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of the following:

(1) The reserve calculated according to the method, the mortality table, and the rate of interest actually used; or

(2) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the guaranteed maturity premium in each policy year for which the valuation net premium exceeds the guaranteed maturity premium.

b. For universal life insurance reserves on a net level premium basis, the valuation net premium is $PVFB/\ddot{a}_x$, and for reserves on a commissioners reserve valuation method, the valuation net premium is $PVFB/\ddot{a}_x + ((a) - (b))/\ddot{a}_x$.

191—92.5(508) Nonforfeiture.

92.5(1) *Minimum cash surrender values for flexible premium universal life insurance policies.*

a. Minimum cash surrender values for flexible premium universal life insurance policies shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately.

b. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

(1) The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to the accumulation

to that date of the premiums paid minus the accumulations to that date of (a) the benefit charges; (b) the averaged administrative expense charges for the first policy year and any insurance-increase years; (c) actual administrative expense charges for other years; (d) initial and additional acquisition expense charges not exceeding the initial or additional expense allowances, respectively; (e) any service charges actually made (excluding charges for cash surrender or election of a paid-up nonforfeiture benefit); and (f) any deductions made for partial withdrawals; all accumulations being at the actual rate or rates of interest at which interest credits have been made unconditionally to the policy (or have been made conditionally, but for which the conditions have since been met), and minus any unamortized unused initial and additional expense allowances.

(2) Interest on the premiums and on all charges referred to in (a) through (f) in subparagraph (1) above shall be accumulated from and to such dates as are consistent with the manner in which interest is credited in determining the policy value.

(3) The benefit charges shall include the charges made for mortality and any charges made for riders or supplementary benefits for which premiums are not paid separately. If benefit charges are substantially level by duration and develop low or no cash values, then the commissioner shall have the right to require higher cash values unless the insurer provides adequate justification that the cash values are appropriate in relation to the policy's other characteristics.

(4) The administrative expense charges shall include charges per premium payment, charges per dollar of premium paid, periodic charges per thousand dollars of insurance, periodic per policy charges, and any other charges permitted by the policy to be imposed without regard to the policyowner's request for services.

(5) The averaged administrative expense charges for any year shall be those which would have been imposed in that year if the charge rate or rates for each transaction or period within the year had been equal to the arithmetic average of the corresponding charge rates which the policy states will be imposed in policy years two through twenty in determining the policy value.

(6) The initial acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in the first policy year over the averaged administrative expense charges for that year. Additional acquisition expense charges shall be the excess of the expense charges, other than service charges, actually made in an insurance-increase year over the averaged administrative expense charges for that year. An insurance-increase year shall be the year beginning on the date of increase in the amount of insurance by policyowner request (or by the terms of the policy).

(7) Service charges shall include charges permitted by the policy to be imposed as a result of a policyowner's request for a service by the insurer (such as the furnishing of future benefit illustrations) or of special transactions.

(8) The initial expense allowance shall be the allowance provided by Iowa Code section 508.37(5)(a)(2) through (4) or by Iowa Code section 508.37(6)(a)(2) and (3) for a fixed premium, fixed benefit endowment policy with a face amount equal to the initial face amount of the flexible premium universal life insurance policy, with level premiums paid annually until the highest attained age at which a premium may be paid under the flexible premium universal life insurance policy, and maturing on the latest maturity date permitted under the policy, if any, otherwise at the highest age in the valuation mortality table. The unused initial expense allowance shall be the excess, if any, of the initial expense allowance over the initial acquisition expense charges.

(9) If the amount of insurance is subsequently increased upon request of the policyowner (or by the terms of the policy), an additional expense allowance and an unused additional expense allowance shall be determined on a basis consistent with subparagraph (8) and with Iowa Code section 508.37(6)(e), using the face amount and the latest maturity date permitted at that time under the policy.

(10) The unamortized unused initial expense allowance during the policy year beginning on the policy anniversary at age x+t (where "x" is the same issue age) shall be the unused initial expense allowance multiplied by $\ddot{a}_{x+t}/\ddot{a}_x$, where $\ddot{a}_{x+t}$ and $\ddot{a}_x$ are present values of an annuity of one per year payable on policy anniversaries beginning at ages x+t and x, respectively, and continuing until the highest attained age at which a premium may be paid under the policy, both on the mortality and interest bases guaranteed in the policy. An unamortized unused additional expense allowance shall be the unused

additional expense allowance multiplied by a similar ratio of annuities, with $\ddot{a}_x$ replaced by an annuity beginning on the date as of which the additional expense allowance was determined.

92.5(2) *Minimum cash surrender values for fixed premium universal life insurance policies.* For fixed premium universal life insurance policies, the minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately:

a. The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to [(A) - (B) - (C) - (D)], where:

(A) is the present value of all future guaranteed benefits;

(B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in Iowa Code section 508.37(5)(a) or Iowa Code section 508.37(6)(a), as applicable. If Iowa Code section 508.37(6)(a) is applicable, the nonforfeiture net level premium is equal to the quantity $PVFB/\ddot{a}_x$, where PVFB is the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer;

$\ddot{a}_x$ is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy;

(C) is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy; $\ddot{a}_x$ shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration;

(D) is the sum of any quantities analogous to (B) which arise because of structural changes in the policy.

b. Future guaranteed benefits are determined by: (1) projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc. contained in the policy or declared by the insurer; and (2) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

c. All present values shall be determined using: (1) an interest rate (or rates) specified by Iowa Code section 508.37(5) and (6) for policies issued in the same year; and (2) the mortality rates specified by Iowa Code section 508.37(5) and (6) for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose.

92.5(3) *Minimum paid-up nonforfeiture benefits.*

a. If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as:

(1) In the case of a flexible premium universal life insurance policy, the mortality and interest bases guaranteed in the policy for determining the policy value; or

(2) In the case of a fixed premium policy, the mortality and interest standards permitted for paid-up nonforfeiture benefits by Iowa Code section 508.37(5) and (6).

b. In lieu of the paid-up nonforfeiture benefit, the insurer may substitute, upon proper request no later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount of death benefits or longer period of death benefits or, if applicable, a greater amount of endowment benefits or earlier payment of endowment benefits.

191—92.6(508) Mandatory policy provisions.

92.6(1) *Periodic disclosure to policyholder.* The policy shall provide that the policyowner be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy. The end of the current report period must be not more than three months prior to the date of the mailing of the report. Specific requirements for this report are detailed in rule 191—92.8(508).

92.6(2) *Current illustrations.* The annual report shall provide notice that the policyholder may request an illustration of current and future benefits and values.

92.6(3) *Policy guarantees.* The policy shall provide guarantees of minimum interest credits and maximum mortality and expense charges. All values and data shown in the policy shall be based on guarantees. Figures based on nonguarantees shall not be included in the policy.

92.6(4) *Calculation of cash surrender values.* The policy shall contain at least a general description of the calculation of cash surrender values including the following information:

a. The guaranteed maximum expense charges and loads;

b. Any limitation on the crediting of additional interest. Interest credits shall not remain conditional for a period longer than 24 months;

c. The guaranteed minimum rate or rates of interest;

d. The guaranteed maximum mortality charges;

e. Any other guaranteed charges; and

f. Any surrender or partial withdrawal charges.

92.6(5) *Changes in basic coverage.* If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether new periods for contestability or suicide apply to the additional amount of coverage.

92.6(6) *Grace period and lapse.* The policy shall provide that written notice be sent to the policyowner's last-known address at least 30 days prior to termination of coverage. A flexible premium policy shall provide for a grace period of at least 30 days after lapse. Unless otherwise defined in the policy, lapse shall occur on that date on which the net cash surrender value first equals zero.

92.6(7) *Misstatement of age or sex.* If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The commissioner may approve other methods which are deemed satisfactory.

92.6(8) *Maturity date.* If a policy provides for a maturity date, end date, or similar date, then the policy shall also contain a statement, in close proximity to that date, noting that it is possible that coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner, if such is the case.

191—92.7(508) Disclosure requirements. Disclosure of information about the policy being applied for shall follow the standards in 191—Chapter 14.

191—92.8(508) Periodic disclosure to policyowner.

92.8(1) *Requirements.* The policy shall provide that the policyowner be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy. The end of the current report period shall be not more than three months previous to the date of the mailing of the report.

92.8(2) *Report contents.* The report shall include the following:

a. The beginning date and end date of the current report period;

b. The policy value at the end of the previous report period and at the end of the current report period;

c. The total amounts which have been credited or debited to the policy value during the current report period, identifying each debit or credit by type (e.g., interest, mortality, expense, and riders);

d. The current death benefit at the end of the current report period on each life covered by the policy;

e. The net cash surrender value of the policy as of the end of the current report period;

f. The amount of outstanding loans, if any, as of the end of the current report period;

g. For fixed premium policies, a notice that, 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;

h. For flexible premium policies, a notice that, 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.

191—92.9(508) Interest-indexed universal life insurance policies.

92.9(1) *Initial filing requirements.* The following information shall be submitted in connection with any filing of interest-indexed universal life insurance policies. All such information received shall be treated confidentially to the extent permitted by law.

a. A description of how the interest credits are determined, including:

(1) A description of the index;

(2) The relationship between the value of the index and the actual interest rate to be credited;

(3) The frequency and timing of determining the interest rate; and

(4) The allocation of interest credits, if more than one rate of interest applies to different portions of the policy value.

b. The insurer's investment policy, which includes a description of the following:

(1) How the insurer addresses the reinvestment risks;

(2) How the insurer plans to address the risk of capital loss on cash outflows;

(3) How the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities;

(4) How the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy;

(5) The amount and type of assets currently held for interest-indexed policies; and

(6) The amount and type of assets expected to be acquired in the future.

c. If policies are linked to an index for a specified period that is less than to the maturity date of the policy, a description of the method used (or currently contemplated) to determine interest credits upon the expiration of such period.

d. A description of any interest guarantee in addition to or in lieu of the index.

e. A description of any maximum premium limitations and the conditions under which they apply.

92.9(2) *Additional filing requirements.*

a. Annually, every insurer shall submit a description of the amount and type of assets currently held by the insurer with respect to its interest-indexed policies. The assets described by the insurer pursuant to this paragraph as held by the insurer with respect to its interest-indexed policies shall not be segregated or dedicated to the insurer's interest-indexed policies but shall be general assets of the insurer unless the assets are in one or more separate accounts in accordance with Iowa Code chapter 508A which have been established by the insurer with respect to certain of its interest-indexed policies.

b. Prior to implementation of any material change in the insurer's investment strategy or method of determining the interest credits, every domestic insurer shall submit a description of any material change in the insurer's investment strategy or method of determining the interest credits. A change shall be considered to be material if it will affect the form or definition of the index (i.e., any change in the information supplied pursuant to subrule 92.9(1)) or if it will significantly change the amount or type of assets held for interest-indexed policies.

191—92.10(508) Applicability. Rules 191—92.6(508) through 191—92.8(508) shall apply only to policies issued after July 13, 2005.

These rules are intended to implement Iowa Code sections 508.36 and 508.37.

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CHAPTER 93
CONDUIT DERIVATIVE TRANSACTIONS

191—93.1(511,521A) Purposes. The purposes of these rules are to set standards for aggregated derivative transactions among affiliates in an insurance company holding system, to set standards for conduit derivative transactions between a conduit and external qualified counterparties, and to define which aggregated derivative transactions and conduit derivative transactions are not subject to the provisions of Iowa Code section 521A.5(1)*"b," "c"*(3), and *"e."*

191—93.2(511,521A) Definitions. For purposes of this chapter, the following definitions shall apply:

"Affiliate," or *"affiliate of"* a specific person, means a person who directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"Aggregated derivative transaction" means a derivative transaction entered into between any affiliate within an insurance holding company system and a conduit, which transaction may be aggregated by the conduit with other derivative transactions between the conduit and other affiliates within the insurance holding company system and replicated by the conduit with qualified counterparties. An aggregated derivative transaction does not include an individual derivative transaction between an insurer and a conduit subject to Iowa Code section 521A.5(1)*"b."*

"Conduit" means a corporation, limited liability company, partnership or other similar form of business organization within an insurance holding company system which engages in the business of conduit derivative transactions.

"Conduit derivative transaction" means a derivative transaction entered into between a conduit and a qualified counterparty that is not within the conduit's insurance holding company system and that replicates one or more aggregated derivative transactions.

"Control" means the same as defined in Iowa Code section 521A.1(3).

"Custodian bank" means the same as defined in Iowa Code section 511.8(21)*"a"*(2).

"Derivative" means an agreement, option, instrument, or any series or combination of agreements, options, or instruments that provides for either of the following:

1. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu of such delivery or relinquishment; or
2. Which has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

"Derivative" includes options, warrants not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures and any other agreements, options or instruments substantially similar thereto or any series or combination thereof.

"Derivative transaction" means a transaction based upon a derivative.

"Domestic insurer" means the same as defined in Iowa Code section 521A.1(4).

"Insurance holding company system" means the same as defined in Iowa Code section 521A.1(5).

"Person" means the same as defined in Iowa Code section 521A.1(7).

"Qualified counterparty" means:

1. A qualified exchange;
2. A transaction entered into with, or guaranteed by, a business entity with an investment grade rating by the National Association of Insurance Commissioners (NAIC) Securities and Valuation Office or by a majority of nationally recognized statistical rating organizations (NRSRO), on the NAIC/NRSRO list, that rate the business entity;
3. A qualified foreign exchange; or
4. A derivative instrument issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based.

"Qualified exchange" means the same as defined in rule 191—49.2(511).

"Qualified foreign exchange" means the same as defined in rule 191—49.2(511).

191—93.3(511,521A) Provisions not applicable.

93.3(1) Iowa Code section 521A.5(1)*"b"* shall not be applicable to an aggregated derivative transaction or to a conduit derivative transaction that complies with this chapter.

93.3(2) Iowa Code section 521A.5(1)*"c"*(3) shall not be applicable to an aggregated derivative transaction or to a conduit derivative transaction that complies with this chapter.

93.3(3) Iowa Code section 521A.5(1)*"e"* shall not be applicable to an aggregated derivative transaction or to a conduit derivative transaction that complies with this chapter.

191—93.4(511,521A) Standards for conduit derivative transactions.

93.4(1) *Documentation.* The conduit shall maintain documentation and records relating to each conduit derivative transaction that shall include, but not be limited to, documentation setting forth:

a. The purpose or purposes of the transaction;

b. The specific derivative instrument used in the transaction;

c. For over-the-counter derivative instrument transactions, the name of the qualified counterparty and the counterparty exposure amount calculated not less than quarterly; and

d. For exchange traded derivative instruments, the name of the exchange and the name of the firm that handled the trade.

93.4(2) *Trading requirements.* Each derivative that is the subject of a conduit derivative transaction shall be entered into with a qualified counterparty.

191—93.5(511,521A) Internal controls.

93.5(1) Before engaging in an aggregated derivative transaction or a conduit derivative transaction, the conduit shall have established written guidelines that shall be used for effecting and maintaining such transactions.

93.5(2) The guidelines shall:

a. Address investment or, if applicable, underwriting objectives, risk constraints, and the factors considered in establishing risk constraints such as credit risk limits;

b. Address permissible transactions and the relationship of those transactions to the conduit's operations, such as a precise identification of the risks being hedged by a derivative transaction;

c. Set forth a credit risk management system for over-the-counter derivative transactions that measures credit risk exposure using the qualified counterparty exposure; and

d. Require:

(1) Compliance with internal control procedures;

(2) That the board of directors of the conduit shall approve the guidelines and determine whether the conduit has adequate professional personnel, technical expertise and systems to implement investment practices involving derivatives;

(3) That only the board of directors of the conduit or its authorized designee may approve derivative instrument transactions;

(4) That the board of directors of the conduit or its designee exercise administrative oversight of trading functions;

(5) Periodic reporting of open positions to a responsible officer designated by the board of directors of the conduit; and

(6) That the reports set forth in rule 191—93.6(511, 521A) be filed with the Iowa insurance commissioner as required.

191—93.6(511,521A) Reporting requirements for conduit derivative transactions.

93.6(1) *Reporting frequency.* The conduit shall report conduit derivative transaction activities quarterly to the Iowa insurance commissioner.

93.6(2) *Contents of reports.* The conduit shall report conduit derivative transaction activities consistent with Schedule DB reporting requirements as prescribed by the accounting practices and procedures manual of the National Association of Insurance Commissioners.

191—93.7(511,521A) Conduit ownership. A conduit shall be wholly owned within the insurance holding company system that utilizes the conduit for aggregated derivative transactions and conduit derivative transactions.

191—93.8(511,521A) Exemption from applicability. This chapter shall not apply to any conduit that is not engaging in aggregated derivative transactions with a domestic insurer.

These rules are intended to implement Iowa Code sections 511.8(22)*"b,"* 521A.2(1)*"c,"* and 521A.2(3) as amended by 2006 Iowa Acts, Senate File 2364.

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CHAPTER 94
PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES

191—94.1(508) Purpose. The purpose of this chapter is to recognize, permit and prescribe the use of mortality tables that reflect the differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with Iowa Code section 508.36 and 191—Chapter 47.

191—94.2(508) Definitions. For purposes of this chapter, the following definitions shall apply:

"2001 CSO Mortality Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the National Association of Insurance Commissioners in December 2002 and by the commissioner pursuant to 191—Chapter 91. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002) and supplemented by the 2001 CSO Preferred Class Structure Mortality Table. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2001 CSO Mortality Table include the following:

1. "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.
2. "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

"2001 CSO Preferred Class Structure Mortality Table" means mortality tables with separate rates of mortality for super preferred nonsmoker, preferred nonsmoker, residual standard nonsmoker, preferred smoker, and residual standard smoker splits of the 2001 CSO nonsmoker and smoker tables as adopted by the National Association of Insurance Commissioners at the September 2006 national meeting and published in the NAIC Proceedings (3rd Quarter 2006). Unless the context indicates otherwise, the "2001 CSO Preferred Class Structure Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table. It also includes both the smoker and non-smoker mortality tables, both the male and female mortality tables, the gender composite mortality tables, and both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

"Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

"Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information, with the demonstrated resources for and a history of ongoing electronic communications and data transfer ensuring data integrity for insurer members or subscribers, and with a history of and the means for aggregation of data and accurate promulgation of experience modifications in a timely manner.

191—94.3(508) 2001 CSO Preferred Class Structure Mortality Table. At the election of the company, for each calendar year of issue, for any one or more specified plans of insurance and subject to the conditions stated in this chapter, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. No such election shall be made until the company demonstrates that at least 20 percent of the business to be valued using this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this rule, will be treated as part

of the 2001 CSO Mortality Table for purposes of reserve valuation only, pursuant to the requirements of the National Association of Insurance Commissioners' model regulation, "Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits Model Regulation."

191—94.4(508) Conditions.

94.4(1) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued pursuant to the residual standard nonsmoker table, the appointed actuary shall certify that:

a. The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

b. The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

94.4(2) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

a. The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

b. The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

94.4(3) Unless exempted by the commissioner, every authorized insurer using the 2001 CSO Preferred Class Structure Mortality Table shall annually file with the commissioner, with the National Association of Insurance Commissioners, or with a statistical agent designated by the National Association of Insurance Commissioners and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this chapter. The form of the reports shall be established by the commissioner, or the commissioner may require the use of a form established by the National Association of Insurance Commissioners or by a statistical agent designated by the National Association of Insurance Commissioners and acceptable to the commissioner.

191—94.5(508) Separability. If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid, the remainder of this chapter and the application of such provision to other persons or circumstances shall not be affected.

These rules are intended to implement Iowa Code sections 505.8 and 508.36.

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CHAPTER 95
DETERMINING RESERVE LIABILITIES FOR PRENEED LIFE INSURANCE

191—95.1(508) Authority. This chapter is promulgated by the commissioner of insurance pursuant to Iowa Code sections 508.36 and 508.37.

191—95.2(508) Scope. These rules apply to preneed insurance, as defined in rule 95.4(508) of this chapter, and to similar policies and certificates.

191—95.3(508) Purpose. The purpose of this chapter is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioner Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products.

191—95.4(508) Definitions. For purposes of this chapter, the following definitions shall apply:

"2001 CSO Mortality Table" or *"2001 CSO"* means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"Preneed insurance" means any life insurance policy or contract or certificate that is issued in combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods and services to be provided at the time of and immediately following the death of the insured. Goods and services may include, but are not limited to, embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone, and transportation of the deceased. The status of the policy or contract as preneed insurance is determined at the time of issue in accordance with the policy form filing.

"Ultimate 1980 CSO" means the Commissioners' 1980 Standard Ordinary Life Valuation Mortality Tables (1980 CSO) without ten-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

191—95.5(508) Minimum valuation mortality standards. For preneed insurance contracts and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the ultimate 1980 CSO.

191—95.6(508) Minimum valuation interest rate standards.

95.6(1) The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as described in Iowa Code section 508.36(5)*"b."*

95.6(2) The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as described in Iowa Code section 508.37(6)*"i."*

191—95.7(508) Minimum valuation method standards.

95.7(1) The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method described in Iowa Code section 508.36.

95.7(2) The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method described in Iowa Code section 508.37.

191—95.8(508) Transition rules.

95.8(1) For preneed insurance policies issued on or after January 1, 2009, and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

95.8(2) If an insurer elects to use the 2001 CSO as a minimum standard for any policy issued on or after January 1, 2009, and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

a. A complete list of all preneed policy forms that use the 2001 CSO as a minimum standard;

b. A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed policies issued on or after January 1, 2009, and using the 2001 CSO as a minimum standard, develops adequate reserves. For the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies; and

c. Supporting information regarding the adequacy of reserves for preneed insurance policies issued on or after January 1, 2009, and using the 2001 CSO as a minimum standard for reserves.

95.8(3) Preneed insurance policies issued on or after January 1, 2012, must use the ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

191—95.9(508) Effective date. This chapter is applicable to preneed insurance policies and certificates and similar contracts and certificates, as specified in rule 95.2(508) of this chapter, issued on or after January 1, 2009.

These rules are intended to implement Iowa Code sections 508.36 and 508.37.

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CHAPTERS 96 and 97
Reserved

CHAPTER 98
ANNUAL FINANCIAL REPORTING REQUIREMENTS
[Prior to January 1, 2010, see 191—5.25(505)]

191—98.1(505) Authority. This chapter is promulgated by the commissioner of insurance pursuant to Iowa Code section 505.8.

191—98.2(505) Purpose. The purpose of this chapter is to improve the Iowa insurance division's surveillance of the financial condition of insurers by requiring an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, Communication of Internal Control Related Matters Noted in an Audit, and Management's Report of Internal Control Over Financial Reporting.

98.2(1) Every insurer (as defined in rule 98.3(505)) shall be subject to this chapter. Insurers having direct premiums written in this state of less than $1 million in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this chapter for such year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities), except that insurers having assumed premiums pursuant to contracts or treaties of reinsurance of $1 million or more will not be so exempt.

98.2(2) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from rules 98.4(505) through 98.12(505) and 98.17(505) if:

a. A copy of the audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the letter to the insurer with the accountant's qualifications that are filed with such other state are filed with the commissioner in accordance with the filing dates specified in rules 98.4(505), 98.11(505), and 98.17(505), respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions Canada).

b. A copy of any Notification of Adverse Financial Condition Report filed with such other state is filed with the commissioner within the time specified in rule 98.10(505).

98.2(3) Foreign or alien insurers required to file Management's Report of Internal Control Over Financial Reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

98.2(4) This chapter shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers pursuant to Iowa Code chapter 507.

191—98.3(505) Definitions. The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this chapter.

"Accountant" or *"independent certified public accountant"* means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which the individual or firm is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

"Affiliate" of, or person *"affiliated with,"* a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this chapter at the election of the

controlling person. Refer to subrule 98.13(5) for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

"Audited financial report" means and includes those items specified in rule 98.5(505).

"Group of insurers" means those licensed insurers included in the reporting requirements of Iowa, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

"Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

"Independent board member" has the same meaning as described in subrule 98.13(3).

"Insurer" means a licensed insurer under Title XIII of the Iowa Code, except entities organized under Iowa Code chapters 512A, 512B, 518, and 518A.

"Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in paragraphs *"b"* through *"g"* of subrule 98.5(2), and includes those policies and procedures that: (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in paragraphs *"b"* through *"g"* of subrule 98.5(2), and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in paragraphs *"b"* through *"g"* of subrule 98.5(2).

"NAIC" means the National Association of Insurance Commissioners.

"SEC" means the United States Securities and Exchange Commission.

"Section 404" means Section 404 of the Sarbanes-Oxley Act, 15 U.S.C. Section 7262, and the SEC's rules and regulations promulgated thereunder.

"Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant.

"SOX" means the Sarbanes-Oxley Act of 2002, Pub.L.107-204, 116 Stat.745.

"SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of SOX: (1) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934, 15 U.S.C. Section 78j-l(i)); (2) the audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934, 15 U.S.C. Section 78j-l(m)(3)); and (3) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K, 17 C.F.R. Section 228.308).

191—98.4(505) General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment.

98.4(1) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with 90 days' advance notice to the insurer.

98.4(2) Extensions of the June 1 filing date may be granted by the commissioner for 30-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

98.4(3) If an extension is granted in accordance with the provisions of rule 98.4(505), a similar extension of 30 days is granted to the filing of Management's Report of Internal Control Over Financial Reporting.

98.4(4) Every insurer required to file an annual audited financial report pursuant to this chapter shall designate a group of individuals who shall constitute its audit committee. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this chapter at the election of the controlling person.

191—98.5(505) Contents of annual audited financial report.

98.5(1) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the division of insurance of the state of domicile.

98.5(2) The annual audited financial report shall include the following:

a. Report of independent certified public accountant.

b. Balance sheet reporting admitted assets, liabilities, capital and surplus.

c. Statement of operations.

d. Statement of cash flow.

e. Statement of changes in capital and surplus.

f. Notes to financial statements. These notes shall be those required by the appropriate National Association of Insurance Commissioners (NAIC) Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Iowa Code sections 508.11 and 515.63, with a written description of the nature of these differences.

g. The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

191—98.6(505) Designation of independent certified public accountant. Each insurer required by this chapter to file an annual audited financial report must, within 60 days after becoming subject to such requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit as set forth in this chapter. Insurers not retaining an independent certified public accountant on January 1, 2010, shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first audited financial report is to be filed.

98.6(1) The insurer shall obtain a letter from the accountant, and file a copy with the commissioner, stating that the accountant is aware of the provisions of Title XIII of the Iowa Code and administrative rules thereunder that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the insurance division, specifying such exceptions as the accountant may believe appropriate.

98.6(2) If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five business days notify the division of this event. The insurer shall also furnish the commissioner with a separate letter within ten business days of the above notification stating whether in the 24 months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and if any such disagreements, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this rule include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this rule are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for the

presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request such former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

191—98.7(505) Qualifications of independent certified public accountant.

98.7(1) The commissioner shall not recognize any person or firm as a qualified independent certified public accountant that:

a. Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, is not a chartered accountant; or

b. Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as indemnification) with respect to the audit of the insurer.

98.7(2) Except as otherwise provided herein, independent certified public accountants shall be recognized as qualified as long as they conform to the standards of their profession, as contained in the Code of Professional Ethics of the AICPA and rules and regulations and the code of ethics and rules of professional conduct of the Iowa accountancy examining board, or similar code.

98.7(3) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Iowa Code chapter 507C, the mediation or arbitration provisions shall operate at the option of the statutory successor.

98.7(4) The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least 30 days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

a. Number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm;

b. Premium volume of the insurer; or

c. Number of jurisdictions in which the insurer transacts business.

98.7(5) The insurer shall file, with its annual statement filing, the approval for relief from subrule 98.7(4) with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

98.7(6) The commissioner shall neither recognize as a qualified independent certified public accountant nor accept any annual audited financial report prepared in whole or in part by any natural person who:

a. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

b. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this chapter; or

c. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this chapter.

98.7(7) The commissioner of insurance, under 191—Chapter 3, may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing the opinion of the accountant on the financial statements in the annual audited financial report made pursuant to this chapter and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this chapter.

98.7(8) The commissioner shall not recognize as a qualified independent certified public accountant or accept an annual audited financial report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following nonaudit services:

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer;

b. Financial information systems design and implementation;

c. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

d. Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(1) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(2) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(3) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

e. Internal audit outsourcing services;

f. Management functions or human resources;

g. Broker or dealer, investment adviser, or investment banking services;

h. Legal services or expert services unrelated to an audit; or

i. Any other services that the commissioner determines, by rule, are impermissible.

98.7(9) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit the accountant's own work, and cannot serve in an advocacy role for the insurer.

98.7(10) Insurers having direct written and assumed premiums of less than $100 million in any calendar year may request an exemption from subrule 98.7(8). The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with subrule 98.7(8) would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

98.7(11) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services that are not described in subrule 98.7(8) or that do not conflict with subrule 98.7(9), only if the activity is approved in advance by the audit committee, in accordance with subrule 98.7(12).

98.7(12) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity or if:

a. The aggregate amount of all such nonaudit services provided to the insurer constitutes not more than 5 percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided;

b. The services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

c. The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

98.7(13) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subrule 98.7(12). The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

98.7(14) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This subrule shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

98.7(15) The insurer shall file, with its annual statement filing, the approval for relief from the requirements of subrule 98.7(14) with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

191—98.8(505) Consolidated or combined audits. An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report as follows:

1. Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.
2. Amounts for each insurer subject to this rule shall be stated separately.
3. Noninsurance operations may be shown on the worksheet on a combined or individual basis.
4. Explanations of consolidating and eliminating entries shall be included.
5. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

191—98.9(505) Scope of audit and report of independent certified public accountant. Financial statements furnished pursuant to rule 98.5(505) shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a Management's Report of Internal Control Over Financial Reporting pursuant to rule 98.15(505), the independent certified public accountant should consider (as that term is defined in Statement on Auditing Standards (SAS) No. 102, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

191—98.10(505) Notification of adverse financial condition.

98.10(1) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of

the balance sheet date currently under audit or that the insurer does not meet the applicable minimum capital and surplus requirements of Iowa Code sections 508.5, 508.10, 515.8, 515.10 and 515.12(5) as of that date. An insurer who has received a report pursuant to this rule shall forward a copy of the report to the commissioner within five business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five-business-day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five business days.

98.10(2) No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with subrule 98.10(1) if such statement is made in good faith in compliance with this rule.

98.10(3) If the accountant, subsequent to the date of the audited financial report filed pursuant to this chapter, becomes aware of facts which might have affected this report, the insurance division notes the obligation of the accountant to take such action as prescribed in Volume 1, AU Section 561 of the Professional Standards of the AICPA.

191—98.11(505) Communication of Internal Control Related Matters Noted in an Audit. In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within 60 days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term "material weakness" is defined by Statement on Auditing Standard 60, Communication of Internal Control Related Matters Noted in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in rule 98.4(505)) in the insurer's internal control over financial reporting noted by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

191—98.12(505) Definition, availability and maintenance of independent certified public accountants' work papers. Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the accountant's audit of the financial statements of an insurer and which support the accountant's opinion.

98.12(1) Every insurer required to file an audited financial report pursuant to this chapter shall require the accountant to make available for review by insurance division examiners all work papers prepared in the conduct of the accountant's audit and any communications between the accountant and the insurer that are related to the audit at the offices of the insurer, at the insurance division, or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the insurance division has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

98.12(2) In the conduct of the aforementioned periodic review by the insurance division examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the division. Such reviews by the division examiners shall be considered investigations, and all work papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the division.

191—98.13(505) Requirements for audit committees. This rule shall not apply to foreign or alien insurers licensed in this state or to an insurer that is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity.

98.13(1) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this chapter. Each accountant shall report directly to the audit committee.

98.13(2) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subrule 98.13(5).

98.13(3) In order to be considered independent for purposes of this rule, a member of the audit committee may not, other than in the member's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes unless they are officers or employees of the insurer or one of its affiliates.

98.13(4) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to no longer be independent.

98.13(5) To exercise the election of the controlling person to designate the audit committee for purposes of this chapter, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and shall include a description of the basis for the election. The election may be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity until rescinded.

98.13(6) The audit committee shall require the accountant that performs for an insurer any audit required by this chapter to timely report to the audit committee in accordance with the requirements of SAS 61, Communication with Audit Committees, or its replacement, including:

a. All significant accounting policies and material permitted practices;

b. All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, the ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

c. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

98.13(7) If an insurer is a member of an insurance holding company system, the reports required by subrule 98.13(6) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

98.13(8) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300 million	Over $300 million - $500 million	Over $500 million
No minimum requirements.	Majority (50 percent or more) of members shall be independent.	Supermajority of members (75 percent or more) shall be independent.

a. The commissioner has the authority to require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in any RBC action level event, meets

one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

b. Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

98.13(9) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $500 million may make application to the commissioner for a waiver from the requirements of this rule based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this rule with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

191—98.14(505) Conduct of insurer in connection with the preparation of required reports and documents.

98.14(1) No director or officer of an insurer shall, directly or indirectly:

a. Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this chapter; or

b. Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this chapter.

98.14(2) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this chapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

98.14(3) For purposes of subrule 98.14(2), actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

a. To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

b. Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

c. Not to withdraw an issued report; or

d. Not to communicate matters to an insurer's audit committee.

191—98.15(505) Management's Report of Internal Control Over Financial Reporting.

98.15(1) Every insurer required to file an audited financial report pursuant to this chapter that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500 million or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under rule 98.11(505). Management's Report of Internal Control Over Financial Reporting shall be as of December 31 immediately preceding.

98.15(2) Notwithstanding the premium threshold in subrule 98.15(1), the commissioner may require an insurer to file Management's Report of Internal Control Over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be hazardous to policyholders, creditors or the general public.

98.15(3) An insurer or a group of insurers that is (1) directly subject to Section 404; part of a holding company system whose parent is directly subject to Section 404; not directly subject to Section 404 but is a SOX compliant entity; or a member of a holding company system whose parent is not directly subject

to Section 404 but is a SOX compliant entity may file its or its parent's Section 404 Report and an addendum in satisfaction of this rule's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in subrule 98.5(2), paragraphs *"b"* through *"g"*) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in subrule 98.5(2), paragraphs *"b"* through *"g"*) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (1) a report as described in this rule, or (2) the Section 404 Report and a report as described in this rule for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

98.15(4) Management's Report of Internal Control Over Financial Reporting shall include:

a. A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

b. A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

c. A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

d. A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

e. Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting;

f. A statement regarding the inherent limitations of internal control systems; and

g. Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

98.15(5) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subrule 98.15(4), are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

a. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

b. Management's Report of Internal Control Over Financial Reporting, required by subrule 98.15(1), and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the state insurance department.

191—98.16(505) Exemptions. Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of this chapter if the commissioner finds, upon review of the application, that compliance with this chapter would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this chapter, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with 191—Chapter 3.

191—98.17(505) Letter to insurer with accountant's qualifications. The accountant shall furnish the insurer, in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

1. That the accountant is independent with respect to the insurer and conforms to the standards of the accountant's profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the rules of professional conduct of the Iowa accountancy examining board, or similar code.

2. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this chapter shall be construed as prohibiting the accountant from utilizing such staff as is deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

3. That the accountant understands the annual audited financial report and the opinion thereon will be filed in compliance with this chapter and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

4. That the accountant consents to the requirements of rule 98.18(505) and that the accountant consents and agrees to make available for review by the commissioner, or a designee or appointed agent, the workpapers, as defined in rule 98.12(505).

5. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA.

6. A representation that the accountant is in compliance with the requirements of rule 98.7(505).

191—98.18(505) Canadian and British companies. In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervisory authority, duly audited by an independent chartered accountant. For such insurers, the letter required in rule 98.6(505) shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to rule 98.4(505).

191—98.19(505) Severability provision. 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 chapter or the applicability of its provision to other persons or circumstances shall not be affected.

191—98.20(505) Effective date. This chapter is applicable on or after January 1, 2010.

These rules are intended to implement Iowa Code section 505.8.

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CHAPTER 99
Reserved

REGULATED INDUSTRIES
SALES OF CEMETERY MERCHANDISE, FUNERAL MERCHANDISE AND FUNERAL SERVICES

CHAPTER 100
GENERAL PROVISIONS

191—100.1(523A) Purpose. This chapter and 191—Chapters 101 through 106 are promulgated to implement and administer the provisions of Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559 [2007 Iowa Code Supplement chapter 523A], and 2008 Iowa Acts, Senate File 2349 and House File 2555, which regulate the sale of cemetery merchandise, funeral merchandise, funeral services and any combination of those items. The provisions of this chapter also apply to 191—Chapters 101 through 106.

191—100.2(523A) Definitions. For purposes of 191—Chapters 100 through 106, the definitions in Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, are incorporated by reference. In addition, the following definitions shall apply:

"Active license" means a license that is in effect and in good standing.

"Commissioner" means the Iowa insurance commissioner or staff of the Iowa insurance division as designated by the commissioner.

"Commissioner's Web site" means the Web site of the Iowa insurance division, www.iid.state.ia.us.

"Continuing education" means planned, organized learning acts designed to maintain, improve, or expand a licensee's knowledge and skills to maintain and improve compliance with 191—Chapters 100 through 106 and Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, and to maintain and improve the safety and welfare of the public.

"Credit" means at least 50 minutes spent by a licensee in actual attendance at and in completion of an approved continuing education activity. A credit may also be given for independent study.

"Discipline" means any civil penalty or sanction that the commissioner imposes upon a licensee.

"Expired license" means a license that has not been renewed by the renewal date.

"Inactive license" means a license that has been placed on inactive status by the commissioner at the request of the licensee.

"Independent study" means a subject, program or activity that a person pursues autonomously that meets the standards for approval criteria in these rules and includes a test at the conclusion of the study. Independent study includes programs conducted using television, the Internet, video, sound-recorded programs, correspondence work, and other similar media.

"License" means a preneed seller license or a sales agent license issued pursuant to 191—Chapter 103 or 191—Chapter 104 and Iowa Code chapter 523A.

"License certificate" means any document issued by the commissioner as evidence that a person is licensed with the commissioner.

"Licensed person" means any person who holds a preneed seller or sales agent license pursuant to Iowa Code chapter 523A, including any person who holds an inactive license.

"Licensee" means any person to whom the commissioner has issued a preneed seller license or sales agent license.

"License renewal date" means the date assigned by the commissioner for renewal of a license.

"Licensure" means the granting of a license by the commissioner pursuant to Iowa Code chapter 523A.

"Review" means the commissioner's verification of satisfactory completion of continuing education requirements during a specified time period for certain licensees and persons, as selected by the commissioner, presenting or sponsoring continuing education activities.

"Unlicensed person" means any person who does not have a preneed seller or sales agent license pursuant to Iowa Code chapter 523A, including any person who surrendered a license to the commissioner and any person whose license was revoked by the commissioner.

191—100.3(523A) Contact and correspondence.

100.3(1) *Contact information.* All mailed complaints, inquiries and correspondence shall be sent to Securities and Regulated Industries Bureau, Iowa Insurance Division, 340 Maple Street, Des Moines, Iowa 50319-0066. Telephone inquiries may be made at (877)955-1212. E-mail correspondence may be made through the commissioner's Web site: www.iid.state.ia.us.

100.3(2) *Complaints, inquiries and correspondence.* The commissioner may receive and process any complaint made regarding cemetery merchandise, funeral merchandise, funeral services or any combination of those items, or regarding a sales agent or a preneed seller that alleges certain acts or practices which may constitute one or more violations of the provisions of 191—Chapters 100 to 106 or of Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, or 2008 Iowa Acts, Senate File 2349 and House File 2555. Where appropriate, the commissioner may refer complaints, in whole or in part, to other agencies. Any member of the public or the industry, or any federal, state, or local official, may make and file a complaint with the commissioner. Complaints may be received from sources outside the state of Iowa and processed in the same manner as those originating in Iowa. If required by the commissioner, complaints shall be made on forms prescribed and provided by the commissioner.

100.3(3) *Forms and instructions.* Copies of all required forms and instructions are available on the commissioner's Web site and may be obtained by mail.

191—100.4(523A) Fees.

100.4(1) *Manner of payment.* Fees required by 191—Chapters 100 through 106 may be paid by check, credit card, or electronically, if available, or as directed by the commissioner.

100.4(2) *Nonrefundable.* Fees are not refundable.

100.4(3) *Fee for paper filing.* The commissioner shall assess a $25 processing fee, to reimburse the commissioner for expenses in processing the filing, for any filing submitted in a nonelectronic format, if electronic filing is available through the commissioner's Web site.

100.4(4) *Specific fees.* Except as stated in these rules, fees are set by statute.

a. The license fee for a preneed seller pursuant to 191—paragraph 103.2(1)*"g"* is $100 plus $15 for each criminal history background check request that the commissioner needs to make.

b. The license fee for a sales agent pursuant to 191—paragraph 103.2(2)*"f"* is $20 plus $15 for each criminal history background check request that the commissioner needs to make.

c. The fee for a four-year license renewal for a preneed seller or sales agent pursuant to 191—subrule 103.4(3) is $20.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 101
TRUST DEPOSITS AND TRUST FUNDS

191—101.1(523A) Trust income withdrawals. Trust income may be withdrawn on purchase agreements executed on or after July 1, 2007, as set forth in this chapter, by any preneed seller that is a limited liability corporation that was formed in 2002 for the purpose of purchasing a cemetery from a foreign entity reorganizing under bankruptcy, if the corporation is comprised of six establishments all located within the same county.

191—101.2(523A) Amount of trust income withdrawn. The amount of income withdrawn pursuant to rule 101.1(523A) may not exceed the difference between the amount needed to adjust the trust funds for inflation, as set by the commissioner based on the consumer price index in rule 101.7(523A), and the interest or income earned during the preceding year but, in any event, may not exceed 50 percent of the total interest or income on a calendar-year basis. A portion of trust income must remain in trust and cannot be withdrawn by the preneed seller. This amount is the greater of the following: one-half of the aggregate income and interest credited to the trust during the preceding calendar year; or an amount equal to the consumer price index adjustment for the preceding year.

191—101.3(523A) Allocation of trust income to purchasers' accounts. Income distributions withdrawn from the trust shall be allocated to purchasers' accounts remaining in the trust at the end of the month in which the distribution was made and on the basis that each such account's income balance for that month bears to the aggregate income balances of all such accounts. By September 1, any income not withdrawn pursuant to this chapter shall be allocated to purchasers' accounts remaining in trust at the end of the month in which the allocations were made.

191—101.4(523A) Credit for trust income withdrawn. The early withdrawal of interest or income under this chapter does not affect the purchaser's right to a credit of such interest or income in the event of a nonguaranteed price agreement, cancellation of the purchase agreement, or nonperformance by the preneed seller.

191—101.5(523A) Time period during which trust income may be withdrawn. Income withdrawals permitted by this chapter shall be made no later than 180 days after the calendar year in which the income was earned.

191—101.6(523A) Application of contract law. In any situation in which this chapter and the terms and conditions of a purchase agreement do not conflict, the terms and conditions of the purchase agreement shall govern the withdrawal of trust income and interest. The ability to withdraw income and interest may be limited or prohibited by the terms of a purchase agreement. However, in the event of a conflict with the limitations set forth in this chapter, the preneed seller must comply with the requirements of this chapter.

191—101.7(523A) Consumer price index adjustment.

101.7(1) Pursuant to Iowa Code Supplement sections 523A.201(8) and 523A.602(2)*"b"*(1), the commissioner sets the following inflation adjustment factors for the years listed for the purposes of calculating the amount of interest or income earned on amounts deposited in trust that must remain trust funds as an adjustment for inflation or to adjust the purchase price of merchandise and services in order to calculate the amount of a cancellation refund.

2007	4.1%
2006	2.5%
2005	3.4%
2004	3.3%

2003	1.9%
2002	2.4%
2001	1.6%
2000	3.4%
1999	2.7%
1998	1.6%
1997	1.7%
1996	3.3%
1995	2.5%
1994	2.7%
1993	2.7%
1992	2.9%
1991	3.1%
1990	6.1%
1989	4.6%
1988	4.4%
1987	4.4%

101.7(2) The inflation adjustment factors for years 2008 and later will be set by the commissioner and posted on the commissioner's Web site.

191—101.8(523A) Cancellation refunds. The requirement set forth in Iowa Code Supplement section 523A.602(2)*"b"*(1) applies to any purchase agreement executed on or after July 1, 2001.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 102
WAREHOUSED MERCHANDISE

191—102.1(523A) Funeral and cemetery merchandise delivered to the purchaser or warehoused.

102.1(1) *Applicability.* This chapter applies only to storage existing on or before July 1, 2007, under purchase agreements executed between July 1, 1987, and July 1, 2007. Effective July 1, 2007, warehousing is no longer an alternative to the trust requirements of Iowa Code chapter 523A.

102.1(2) *Approval of storage facilities by commissioner.* If a preneed seller receives approval in writing from the commissioner, the trust requirements of Iowa Code Supplement sections 523A.201 and 523A.202 do not apply, either to payments for outer burial containers made of either polystyrene or polypropylene or to cemetery merchandise delivered to the purchaser or stored in an independent third-party storage facility not owned or controlled by the preneed seller.

191—102.2(523A) Storage facilities. The commissioner shall approve a storage facility's application to be designated as an approved storage facility for purposes of rule 102.1(523A) upon satisfaction of the following conditions:

102.2(1) *Insurance coverage and financial condition.* The applicant must demonstrate that adequate insurance against loss and damage has been purchased and that the applicant's financial condition is commensurate with any financial obligations assumed in the operation of the storage facility. Proof of the applicant's financial condition shall include submission of audited financial statements completed in accordance with generally accepted accounting principles, which shall include the following:

a. A balance sheet prepared as of a date within 120 days prior to the application; and

b. For each of the three fiscal years preceding the date of the balance sheet or, if the applicant has been in existence less than three years, for the period of the applicant's existence, a profit and loss statement and any changes in financial position.

102.2(2) *Record-keeping system.* The applicant must demonstrate that the applicant has an adequate record-keeping system that records for each item in storage: an identification and a description; the ownership, name, and address of the preneed seller; an order number; the order date; and the storage date. The record-keeping system also must be able to provide an aggregate listing and numerical totals for the entire storage facility and for each state or province.

102.2(3) *Title.* The storage facility must undertake to deliver a minimum of two copies of some form of title certificate to the preneed seller, with at least one copy marked as the preneed seller's copy and at least one copy marked as the purchaser's copy. Each preneed seller shall be required to deliver at least one copy to the purchaser and to retain one copy in the preneed seller's records. Certificates of ownership should not be issued until the merchandise is stored in substantially complete condition.

102.2(4) *Delivery requirements.*

a. The applicant must undertake to require the purchaser's signature, or the signature of the purchaser's legal representative, prior to the delivery of the cemetery merchandise.

b. The storage facility must undertake not to accept prepayment of delivery expenses or charges. Appropriate written disclosure that delivery costs will be billed at the time of delivery shall be provided to the preneed seller.

102.2(5) *Storage requirements.* The storage facility must demonstrate that the applicant has an adequate storage system that provides both accessibility and protection against damage. The storage facility must undertake that all cemetery merchandise will be substantially complete prior to storage.

102.2(6) *Consent to audits and inspections.* The applicant must file a written consent authorizing audits, reviews and inspections by the commissioner.

102.2(7) *Statutory compliance with other state or provincial laws.* The applicant shall be in compliance with all applicable laws regulating the applicant's activities as a warehouse keeper, manufacturer, supplier, or preneed seller of cemetery merchandise.

102.2(8) *Identification or personalization of merchandise.* All cemetery merchandise must be appropriately marked, identified, and described in a manner such that it may be distinguished from other similar items of merchandise, unless the commissioner has given prior written waiver of this

requirement upon a showing of good cause. In all instances, the storage facility's storage system shall allow for visual inspection and counting, have storage by type or style, identify the location of the item by a shelf and bin- or slot-type system or reasonable alternative, and keep totals for each type of merchandise item in storage.

102.2(9) *Payment of accounts receivable.* The applicant shall undertake to require payment of all applicable accounts receivable within 90 days of the purchase of the cemetery merchandise.

102.2(10) *Audits and examinations.* The commissioner shall have the right to examine or cause to be examined the books, papers, records, memoranda or other documents of the storage facility and stored merchandise for the purpose of verifying compliance with Iowa Code chapter 523A and this chapter. Unless waived by the commissioner in writing, the transportation, meal and lodging expenses of the auditors and examiners shall be reimbursed by the storage facility.

102.2(11) *Reports.* The commissioner may request reports containing information about the storage program, including but not limited to the following:

a. A description of the storage facility, including the name, address of the principal business office, state or province of organization, date of organization, type of entity (e.g., corporation or partnership), and the location of all storage facilities;

b. A description of the storage program; and

c. A detailed description of all merchandise currently in storage, which shall include all of the following:

(1) The date the merchandise was first placed in storage;

(2) The full name of the purchaser or the person on whose behalf the merchandise was purchased;

(3) The location of the merchandise, which shall include the location within the facility utilizing a numbering system that provides the exact location of each item;

(4) The name and address of the preneed seller;

(5) The total number of items, by category, in storage at the facility for preneed sellers located in this state; and

(6) The total number of items, by category, in storage at the facility.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 103
LICENSING OF PRENEED SELLERS AND SALES AGENTS

191—103.1(523A) Requirement for a preneed seller license or a sales agent license.

103.1(1) No person may sell or offer to sell cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, in Iowa if the sale of the merchandise or services is subject to Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, unless the person holds an active license.

103.1(2) No person may agree to perform any term of an agreement, whether or not pursuant to a written purchase agreement, to furnish cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, in Iowa if the sale of the merchandise or services is subject to Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, unless the person holds an active license.

103.1(3) At the time a purchase agreement is entered into, a person may not accept any payment or funding, including the assignment of ownership of or proceeds from an insurance policy or annuity, related to the purchase of cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, in Iowa if the sale of the merchandise or services is subject to Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, unless the person holds an active license. This rule does not prevent payments to an unlicensed person upon the person's delivery of cemetery merchandise, funeral merchandise or funeral services after the death of a beneficiary, including the payment of the proceeds of an insurance policy or annuity at the time of death of the insured listed on the insurance policy or annuity.

191—103.2(523A) Application and licensing of preneed seller or sales agent.

103.2(1) *Preneed seller application.* A person that desires to be licensed as a preneed seller must satisfy the following requirements:

a. Submit a completed application form, designated by the commissioner, as set forth in subrule 103.2(3);

b. Appoint at least one sales agent, except if the preneed seller is a sole proprietor;

c. Submit a signed waiver allowing the commissioner to request and obtain criminal history data information, pursuant to Iowa Code Supplement section 523A.501(3) as amended by 2008 Iowa Acts, Senate File 2349, section 5, and House File 2555, section 47, for each owner and manager of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, or shareholder with 10 percent or more of the stock who has the ability to control or direct control of trust funds under Iowa Code chapter 523A, as determined by the commissioner;

d. Provide a financial history, if requested by the commissioner, pursuant to Iowa Code Supplement section 523A.501(4) as amended by 2008 Iowa Acts, Senate File 2349, section 6, and House File 2555, section 48, for each owner and manager of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, or shareholder with 10 percent or more of the stock;

e. Provide evidence of a fidelity bond or insurance if required by rule 191—105.5(523A);

f. Have not committed any act that is grounds for denial under subrule 103.2(4); and

g. Pay the appropriate license fee as set forth in rule 191—100.4(523A).

103.2(2) *Sales agent application.* An individual that desires to be licensed as a sales agent pursuant to Iowa Code Supplement section 523A.502 as amended by 2008 Iowa Acts, Senate File 2349, section 7, and House File 2555, sections 49 and 50, must satisfy the following requirements:

a. Be at least 18 years of age;

b. Be appointed by at least one preneed seller and submit evidence of that appointment;

c. Submit a completed application form, designated by the commissioner, as set forth in subrule 103.2(3);

d. Submit a signed waiver allowing the commissioner to request and obtain criminal history data information, pursuant to Iowa Code Supplement section 523A.501(3) as amended by 2008 Iowa Acts, Senate File 2349, section 5, and House File 2555, section 47;

e. Have not committed any act that is grounds for denial under subrule 103.2(4); and

f. Pay the appropriate license fee as set forth in rule 191—100.4(523A).

103.2(3) *Application form.* A person applying for a preneed seller license or sales agent license shall complete an application form designated by the commissioner in accordance with the instructions supplied with the form. The appropriate application form and instructions may be obtained from the commissioner's Web site.

103.2(4) *Approval or denial of applications.*

a. If the application form is not completed according to the instructions, or if all of the information in the instructions or requested by the commissioner is not provided, the commissioner shall send a deficiency letter to the applicant, identifying the problems with the license application and listing any required corrective action. The commissioner shall suspend review of the application until the applicant successfully provides the necessary information. If an applicant does not satisfy the terms of the deficiency letter within two months, the application will expire and a new application form must be submitted.

b. The commissioner may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a license. The commissioner also may request fingerprints and reimbursement of costs for investigating a criminal history, pursuant to Iowa Code Supplement section 523A.501(3) as amended by 2008 Iowa Acts, Senate File 2349, section 5, and House File 2555, section 47.

c. The commissioner shall conduct the criminal history data request and other investigations pursuant to Iowa Code Supplement section 523A.502(4) as amended by 2008 Iowa Acts, House File 2555, section 49. The commissioner's investigation of criminal history data and financial history shall be limited to persons who have the ability to control or direct control of trust funds under Iowa Code chapter 523A, as determined by the commissioner.

d. In order to determine whether to approve or deny an application for license, the commissioner shall review all information that is submitted with the application, submitted at the commissioner's request, obtained through criminal history investigation, and obtained through the financial history review, pursuant to Iowa Code Supplement sections 523A.501(3) and 523A.502(4) as amended by 2008 Iowa Acts, House File 2555, sections 47 and 49, respectively.

e. If the commissioner approves the application and accompanying information, the commissioner shall issue a license, the term of which shall be four years.

f. The commissioner may deny a license application based on information received during the application process or on any ground provided to discipline a license in 191—Chapter 105 or Iowa Code chapter 523A.

191—103.3(523A) Change of ownership or sale of business of preneed seller.

103.3(1) If there is a change in the ownership of a preneed seller, including any change of controlling interest in any corporation or other business entity, the preneed seller shall notify the commissioner of the change within 30 days of the sale and shall provide information as requested by the commissioner to obtain a new preneed seller license.

103.3(2) If all or part of a business entity that has a preneed seller license is sold in whole or in part, and the business entity has not canceled the license nor has the purchaser of that entity applied for a new license in the purchaser's name within 30 days of the sale, the license shall automatically terminate. For purposes of this rule, sale of a business entity includes any change of controlling interest in any corporation or other business entity.

103.3(3) Failure to notify the commissioner of a change of ownership or sale of all or part of a business as set forth in this rule may be a ground for penalty under 191—subrule 105.6(10).

191—103.4(523A) License renewal.

103.4(1) *License expiration.*

a. Preneed seller licenses expire on the last day of the month of the four-year anniversary of the issue date of the license.

b. Sales agent licenses expire on the last day of the birth month of the licensee four years after the issue date of the license.

103.4(2) *Application for renewal.* A licensee must submit an application for renewal to the commissioner at least 60 days in advance of the expiration date of the license. The licensee is responsible for renewing the license.

103.4(3) *Renewal application form.* An application to renew a preneed seller's license or a sales agent's license shall be submitted on a form required by the commissioner, as directed on the commissioner's Web site, and a renewal applicant shall comply with all instructions on the Web site. In addition:

a. The renewal application shall be accompanied by a fee as set out in rule 191—100.4(523A). Failure to include the proper amount shall be cause for suspension of the application pursuant to subrule 103.4(4).

b. A sales agent must have completed the continuing education required by 191—Chapter 104 and submit with the application documentation verifying completion, as directed on the commissioner's Web site.

103.4(4) *Deficiencies in the application.* If the application form is not completed according to the instructions, or if all of the information in the instructions or requested by the commissioner is not provided, the commissioner will send a deficiency letter to the applicant, identifying the problems with the license application and listing any required corrective action, and the commissioner will suspend review of the application until the applicant successfully completes the application form in accordance with the instructions. If an applicant does not satisfy the terms of the deficiency letter within two months, the application shall expire, and a new application form must be submitted. If a licensee fails to submit a timely and sufficient renewal application, the license shall expire.

103.4(5) *Failure to file annual statement.* A sales agent license shall not be renewed if the sales agent did not comply with the requirement to file an annual report, as set forth in 191—paragraph 106.2(3)*"a"* and Iowa Code Supplement section 523A.502A.

103.4(6) *Inactive license, voluntary surrender and license reinstatement.*

a. If a licensed preneed seller does not have at least one appointed sales agent, or if a sales agent is not appointed with at least one preneed seller, the license shall be inactive until a sales agent has been appointed.

b. A preneed seller licensee or a sales agent licensee that has stated an intent to exit the preneed business may voluntarily surrender the license or request that the commissioner place the licensee's license on inactive status.

c. A preneed seller or sales agent must request an inactive status from the commissioner or must surrender the license to the commissioner before the renewal due date or the license shall expire.

d. In no event may a license be inactive for more than 12 months.

e. A preneed seller or sales agent may apply for reinstatement of an inactive license up to 12 months after the license expiration date by submitting the following:

(1) An application for reinstatement, which may be obtained from the commissioner's Web site;

(2) A consent and waiver form required for a background check, if determined necessary by the commissioner;

(3) A financial history for the interim time period after the license became inactive and before the application for reinstatement, if determined necessary by the commissioner;

(4) For a preneed seller, the name of at least one appointed sales agent or, for a sales agent, the name of at least one preneed seller;

(5) For a sales agent, proof of completion of continuing education requirements found in 191—Chapter 104; and

(6) A license fee as set forth in rule 191—100.4(523A), if determined applicable by the commissioner.

f. A preneed seller or sales agent that surrendered a license for a nondisciplinary reason more than 90 days before the expiration date of the license and stated an intent to exit the preneed business may file a request to reinstate the license. The request must be received by the commissioner within 90 days of the date the license was terminated by the commissioner and should include the information set forth in paragraph 103.4(6)*"e."* The request will be granted if the preneed seller or sales agent is otherwise eligible to receive the license. If the request is not received within 90 days, the preneed seller or sales agent must apply for a new license.

191—103.5(523A) Denial of license applications or of applications for renewal.

103.5(1) *Notice of denial.* When the commissioner denies an application for an initial preneed seller license or for the renewal of a preneed seller license, the commissioner shall send a denial letter to the applicant by certified mail, return receipt requested, or in the manner of service of an original notice. The denial letter shall serve as notice of the denial and shall explain why the commissioner denied the application.

103.5(2) *Appeal.* An applicant that desires to contest the denial of an application may request a hearing before the commissioner pursuant to 191—Chapter 3 within 30 calendar days of the date the notice of denial is mailed. If a request for hearing is timely made, the commissioner shall promptly issue a notice of contested case hearing on the grounds asserted by the applicant. A failure to timely request a hearing constitutes failure to exhaust administrative remedies.

103.5(3) *Hearings.* License denial hearings under this chapter shall be conducted pursuant to 191—Chapter 3. License denial hearings and all documents related thereto are contested cases open to the public pursuant to Iowa Code chapters 17A and 22. While each party shall have the burden of establishing the matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

191—103.6(523A) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

103.6(1) The term "reinstatement" as used in this rule means the reinstatement of a suspended license. The term "reissuance" as used in this rule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter. This rule does not apply to the reinstatement of an expired or inactive license.

103.6(2) Any preneed seller whose license has been revoked or suspended by order, or that forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant that shall file with the commissioner an application for reinstatement or reissuance of a license. Instructions regarding how to complete and file an application can be found on the commissioner's Web site.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A preneed seller or sales agent may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding paragraph 103.6(2)*"c"*), revocation, or acceptance of the forfeiture of a license.

103.6(3) All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

103.6(4) An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner deems desirable, which may include one or more of the types of disciplinary sanctions provided by 191—Chapter 106, Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, or 2008 Iowa Acts, Senate File 2349 and House File 2555. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapter 22.

103.6(5) A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

103.6(6) A license may be voluntarily forfeited in lieu of compliance with an order of the commissioner with the written consent of the commissioner. The forfeiture becomes effective when and upon such conditions as required by order of the commissioner, which may include one or more of the types of disciplinary sanctions provided by 191—Chapter 106, Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, or 2008 Iowa Acts, Senate File 2349 and House File 2555.

103.6(7) When a preneed seller's license has been suspended for a period of time which extends beyond the preneed seller's license expiration date, the license will terminate on the license expiration date, and the preneed seller must apply for a new license. If suspension for a period of time ends prior to the preneed seller's license expiration date, the commissioner shall reinstate the license at the end of the suspension period. The commissioner is not prohibited from bringing an additional immediate action if the preneed seller has engaged in misconduct during the period of suspension.

191—103.7(252J) Suspension for failure to pay child support.

103.7(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the sales agent's last-known address by regular mail.

103.7(2) The notice shall contain the following items:

a. A statement that the commissioner intends to suspend the sales agent's application, request for renewal or current insurance license in 30 days;

b. A statement that the sales agent must contact the CSRU to request a withdrawal of the certificate of noncompliance;

c. A statement that the sales agent's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;

d. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

103.7(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the commissioner is notified by the district court of the resolution of the application.

103.7(4) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the commissioner

shall suspend the sales agent's application, request for renewal or current license 30 days after the notice is issued.

103.7(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with rules issued by the commissioner. All fees required for license renewal or license reinstatement must be paid by sales agents, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to this subrule.

191—103.8(261) Suspension for failure to pay student loan.

103.8(1) The commissioner shall deny the issuance or renewal of a sales agent license upon receipt of a certificate of noncompliance from the college student aid commission (CSAC) according to the procedures set forth in Iowa Code sections 261.126 and 261.127. In addition to the procedures contained in those sections, this rule shall apply.

103.8(2) Upon receipt of a certificate of noncompliance from the CSAC according to the procedures set forth in Iowa Code sections 261.126 and 261.127, the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current license will be suspended 60 days after the date of the notice. Notice shall be sent to the sales agent's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed sales agent may accept service personally or through authorized counsel.

103.8(3) The notice shall contain the following items:

a. A statement that the commissioner intends to deny the sales agent's application or request for renewal or suspend the sales agent's license in 60 days;

b. A statement that the sales agent must contact the CSAC to request a withdrawal of the certificate of noncompliance;

c. A statement that the sales agent's application or request for renewal will be denied or the sales agent's license will be suspended if the certificate of noncompliance is not withdrawn or, if the current license is on suspension, a statement that the sales agent's license will be revoked;

d. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 261.127;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

103.8(4) The effective date of revocation or suspension of a sales agent license, as specified in the notice required by Iowa Code section 261.126, shall be 60 days after service of the notice upon the sales agent.

103.8(5) In the event an applicant or licensed sales agent timely files a district court action pursuant to Iowa Code section 261.127, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a sales agent license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

103.8(6) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSAC or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the sales agent's application, request for renewal or current sales agent license 60 days after the notice is issued.

103.8(7) Upon receipt of a withdrawal of the certificate of noncompliance from the CSAC, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have

been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with rules issued by the commissioner. All fees required for license renewal or license reinstatement must be paid by sales agents, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code section 261.126.

103.8(8) The commissioner shall notify the sales agent in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a sales agent license, and shall similarly notify the sales agent when the sales agent's license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

103.8(9) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the CSAC for the sole purpose of identifying a sales agent subject to enforcement under Iowa Code chapter 261.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 104
CONTINUING EDUCATION FOR SALES AGENTS

191—104.1(523A) Continuing education requirements. For each license term, each licensed sales agent shall be required to complete a minimum of eight credits of continuing education approved by the commissioner. At least two credits, to be known as the ethics and legal requirements continuing education requirement, must cover subjects relating to business ethics, the legal requirements of Iowa Code chapter 523A, 191—Chapters 100 through 106, and other relevant federal and state laws and rules, such as the Federal Trade Commission Funeral Rule (16 CFR Part 453).

191—104.2(523A) Acceptable areas of continuing education. The categories of acceptable continuing education include the following:

104.2(1) Ethical behavior related to the death care industry.

104.2(2) Good business practices and procedures related to funeral directors, funeral establishments, cremation establishments and cemeteries.

104.2(3) Legal compliance practices and procedures related to the death care industry, including the sale of funeral merchandise, funeral services, cemetery merchandise and purchase agreements subject to Iowa Code chapter 523A.

104.2(4) Funeral merchandise, funeral services and cemetery merchandise and the regulation of them.

104.2(5) Life insurance and annuity products and the regulation of them.

104.2(6) The Federal Trade Commission Funeral Rule (16 CFR Part 453).

104.2(7) Regulations from the Occupational Safety and Health Administration, the Americans with Disabilities Act and the Environmental Protection Agency.

104.2(8) The estate recovery program and regulations.

104.2(9) Mortuary science law, and public health and technical standards, requirements and issues regarding the handling and interment of deceased human remains.

104.2(10) Business management, accounting and record-keeping practices.

104.2(11) Computer equipment, systems and software.

104.2(12) Other subject areas as approved by the commissioner.

191—104.3(523A) Academic coursework.

104.3(1) Academic coursework that meets the criteria set forth in this chapter is acceptable.

104.3(2) Each credit hour of academic coursework successfully completed by a licensee shall be credited as 1.5 hours of continuing education. This multiplier shall be used only once per biennium for identical or substantially similar presentations.

104.3(3) Continuing education credit equivalents are as follows:

1 academic semester hour = 10 continuing education credits

1 academic trimester hour = 8 continuing education credits

1 academic quarter hour = 7 continuing education credits

191—104.4(523A) Effective date. Continuing education is a prerequisite for the renewal of any sales agent license for which a renewal application is filed on or after July 1, 2008.

191—104.5(523A) Compliance period. A sales agent's continuing education compliance period shall coincide with the sales agent's license term.

191—104.6(523A) Denial of sales agent license renewal application. The commissioner may deny a sales agent license renewal application that does not demonstrate compliance with the rules of this chapter.

191—104.7(523A) Disqualification and replacement of credits. If, as a result of a review, the commissioner determines that certain continuing education coursework does not qualify for credit, a sales agent may be given an opportunity to submit new credits to replace any credits that are not allowed.

191—104.8(523A) Current mailing address. A sales agent's failure to provide a current mailing address to the commissioner and the resulting failure to receive notices or letters from the commissioner regarding continuing education requirements and reporting shall not absolve the sales agent from the requirements of this chapter and shall not provide good cause for any waiver or exemption.

191—104.9(523A) Proof of completion of continuing education requirements. A sales agent is required to maintain a record of all completed continuing education courses by keeping for four years the original certificates of completion and a description and outline of the course attended.

191—104.10(523A) Standards for continuing education activities. A continuing education activity that meets all of the following criteria is appropriate for continuing education credit.

104.10(1) The activity constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

104.10(2) The activity pertains to subject matters which integrally relate to the sale of funeral merchandise, funeral services, cemetery merchandise and purchase agreements subject to Iowa Code chapter 523A including, but not limited to, continuing education subject matter approved for funeral directors and insurance agents;

104.10(3) The activity is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program;

104.10(4) The activity fulfills stated program goals and objectives; and

104.10(5) The person conducting or sponsoring the activity provides proof of attendance to attendees.

191—104.11(523A) Qualifications of presenters and proof of attendance. Proof of attendance at a continuing education activity shall, at a minimum, include the following:

1. The date of the activity, the location of the activity, the course title, and the identity and qualifications of the presenter(s);
2. The number of program contact credits; and
3. A certificate of completion or evidence of successful completion of the course provided by the person conducting or sponsoring the activity.

191—104.12(523A) Reviews.

104.12(1) The commissioner may review licensees and persons conducting or sponsoring continuing education activities to ensure compliance with this chapter.

104.12(2) At the time of a review, the information requested from persons conducting or sponsoring continuing education activities shall include, but not be limited to, the following:

a. The qualifications of presenters.

b. Records documenting licensees' attendance at the activity.

c. A course description.

d. Official school transcripts indicating licensees' successful completion of an academic course.

104.12(3) Upon notice of a continuing education review, a sales agent shall provide the following information to the commissioner:

a. The date and location of the course, course title, course description, course outline, course schedule, names and qualifications of the presenter(s), and the method of presentation or a program brochure or booklet which includes all the information required in this paragraph;

b. The number of contact credit hours attended; and

c. The individual certificate of completion issued or evidence of successful completion of the course from the person conducting or sponsoring the continuing education activity.

191—104.13(523A) Exemption. This rule does not apply to a licensed funeral director or licensed insurance sales agent.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 105
STANDARDS OF CONDUCT AND PROHIBITED PRACTICES

191—105.1(523A) Purpose. This chapter is intended to establish certain minimum standards and guidelines of conduct for preneed sellers and sales agents by identifying required actions and prohibited acts or practices.

191—105.2(523A) Numbering purchase agreements. Preneed sellers shall assign numbers, in sequential order, to each purchase agreement sold during a calendar year.

105.2(1) Prenumbered contracts are not required. If a contract is not prenumbered, the sales agent shall write the contract number on the purchase agreement at the time it is executed.

105.2(2) The copy of the purchase agreement given to the purchaser shall include the contract number assigned to the purchase agreement.

105.2(3) If a correction to the contract number is required, the correction shall be recorded in the sales logs required by subrule 105.3(3), and documentation that retains evidence of the initial number used shall be maintained.

105.2(4) A numbering system that consists of a two-part number separated by a hyphen would satisfy this rule. The first portion of the number would be the date the contract was written. The second portion of the number would be sequential and indicate the number of contracts executed by the preneed seller, to date, in the applicable calendar year. A preneed seller with multiple locations may use a prefix to identify each location by number. A preneed seller with multiple sales agents may use a numerical suffix to identify the sales agent.

191—105.3(523A) Records maintenance.

105.3(1) *Transaction records to be kept by preneed sellers.* A preneed seller shall document all customer transactions and maintain accurate copies and records of all purchase agreements. If no other legal provision governs record retention, a preneed seller shall keep all customer records for a minimum of three years after the date of the death of the beneficiary. The preneed seller shall keep records and the identity of individuals in the records confidential.

105.3(2) *Deposit records to be kept by preneed sellers.* If purchase payments made to a preneed seller are commingled and deposited with funds not related to a purchase agreement subject to Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, or if deposits involve more than one purchase agreement, the preneed seller shall retain a detailed summary of each deposit. This information shall be maintained and shall be available for inspection by the commissioner for a minimum of four years after the deposit.

105.3(3) *Sales log to be kept by preneed sellers.* Preneed sellers shall maintain a sales log for purposes of assigning numbers to purchase agreements. The sales log shall be maintained for a minimum of four years after the date of sale.

105.3(4) *Sales log to be kept by sales agents.* A sales agent shall maintain a sales log for a minimum of four years. The sales log shall include all of the information required for the sales agent's annual report set forth in subrule 105.4(2).

191—105.4(523A) Annual reports.

105.4(1) *Annual reports by preneed sellers.* A licensed preneed seller shall file a completed annual report form with the commissioner on or before April 1 each year. The form and instructions may be obtained through the commissioner's Web site. The report shall include a list of contracts sold during the year covered by the report, including the date of each contract, the total purchase price, the name of the purchaser, the name of the beneficiary and, for each contract sold after July 1, 2007, the number assigned to the contract. Along with submitting the report, the preneed seller shall submit a filing fee, as set forth in Iowa Code Supplement section 523A.204.

105.4(2) *Annual reports by sales agents.* A licensed sales agent shall file a completed annual report form with the commissioner on or before April 1 each year, pursuant to Iowa Code Supplement section

523A.502A. The form and instructions may be obtained through the commissioner's Web site. The report shall include the following:

a. Names of applicable licensed preneed sellers and their license numbers; and

b. A list of contracts sold during the year covered by the report, including the date of the contract, the total purchase price, the name of the purchaser and the name of the beneficiary and, for each contract sold after July 1, 2007, the number assigned to each contract. If the sales agent was appointed by more than one preneed seller, the list of contracts required by this paragraph shall be divided according to each preneed seller.

105.4(3) *Failure to file timely.* If a preneed seller or sales agent fails to file an annual report as required by this subrule on or before the date the annual report is due, the penalties of 191—subrule 106.2(3) shall apply. Additional sanctions pursuant to rule 105.6(523A) and 191—Chapter 106 also may be imposed.

191—105.5(523A) Fidelity bond or insurance. A preneed seller shall obtain and maintain a fidelity bond or similar insurance in an amount not less than $50,000 to protect against the loss of purchaser payments not placed in trust, as required by Iowa Code Supplement section 523A.201(5) unless the preneed seller only uses the trusting alternatives set forth in Iowa Code Supplement section 523A.401 as amended by 2008 Iowa Acts, House File 2555, section 44; Iowa Code Supplement section 523A.402 as amended by 2008 Iowa Acts, House File 2555, section 45; Iowa Code section 523A.403; Iowa Code Supplement section 523A.404; and Iowa Code Supplement section 523A.405 as amended by 2008 Iowa Acts, Senate File 2349, section 4, and House File 2555, section 46, or unless the preneed seller deposits 100 percent of each payment into a trust fund. This requirement may be satisfied by a cash deposit held and administered in trust for the benefit and protection of purchasers and beneficiaries in this state, pursuant to a trust agreement filed with and acceptable to the commissioner.

191—105.6(523A) Grounds for discipline. The commissioner may impose sanctions as set forth in 191—Chapter 106 if the commissioner finds that a licensee or that an owner, partner, member, director, shareholder or manager of a licensed business entity has violated or failed to comply with Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, 2008 Iowa Acts, Senate File 2349 and House File 2555, or any associated rules or implementing orders, including but not limited to the following acts or practices:

105.6(1) *Fraudulent or deceptive applications.* Engaging in fraudulent or deceptive acts in procuring a license, including but not limited to:

a. False representations of a material fact, whether by conduct or by false or misleading statements;

b. Concealing or omitting anything that should have been disclosed or included with the application;

c. Filing a false identification;

d. Filing an untrue certification or affidavit; or

e. Falsifying documents.

105.6(2) *Conviction of a criminal offense.* Conviction of a criminal offense, in any jurisdiction, involving dishonesty or a false statement, including but not limited to fraud, theft, misappropriation of funds, falsification of documents, deceptive acts or practices, or other related offenses. "Conviction" shall include a plea of guilty or a finding of guilt, and shall include a deferred judgment.

105.6(3) *Fraudulent or deceptive practices.* Engaging in any act or practice that violates Iowa Code section 523A.701 or 523A.702, or Iowa Code Supplement section 523A.703, whether or not actual harm or injury occurs, including but not limited to:

a. Making untrue or improbable statements in advertisements;

b. Falsifying business records; or

c. Misappropriating funds.

105.6(4) *Insolvency or financial condition.* Being or becoming insolvent or of unsound financial condition, the determination of which shall be based on but not limited to the following factors:

a. The licensee's or license applicant's net worth;

b. Whether a financial institution has closed or otherwise taken adverse action against an account held by or on behalf of the licensee or license applicant;

c. The licensee or license applicant has exhibited a pattern of writing bad checks or otherwise overdrawing a business or trust account as a result of insufficient funds;

d. Untimely payment by the licensee or license applicant of business obligations in a manner that threatens the operation of the business;

e. Untimely placement by the licensee of consumer funds into trust;

f. Failure of the licensee or license applicant to pay sales, unemployment or other tax owed in the course of business; or

g. Any other act, practice or omission that provides a reasonable basis to question the ability of the licensee or license applicant to comply with the requirements of Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, and related regulations.

105.6(5) *Unethical, harmful or detrimental conduct.* Engaging in any act or practice which may be harmful or detrimental to the public, whether or not actual harm or injury occurs, while engaged in activities regulated by Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, or materially related to such activity, including but not limited to:

a. Encouraging cancellation of a purchase agreement if not in the best interests of the beneficiary;

b. Failure to leave a residence when requested to do so;

c. Intimidation or physical abuse, including improper sexual contact or conduct; or

d. Any other act or practice that takes unfair or unreasonable advantage of the vulnerability of a client or prospective client based on age, poor health, infirmity, impaired understanding, restricted mobility, or disability.

105.6(6) *Failure to maintain records.* Failure to maintain records as required by Iowa Code chapter 523A and 2007 Iowa Acts, Senate File 559, or any associated rules or orders.

105.6(7) *Failure to cooperate with an examination or investigation.* Failure to submit to an examination, failure to comply with a reasonable written request of an examiner, or failure to cooperate with an investigation conducted by the commissioner as required by Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, 2008 Iowa Acts, Senate File 2349 and House File 2555, or any associated rules or orders.

105.6(8) *Late filings or the failure to submit a report.* Filing reports after the filing deadline or failing to file a report as required by Iowa Code chapter 523A or any associated rules or orders.

105.6(9) *Inability to perform.* A preneed seller's failing to be able to provide the cemetery merchandise, funeral merchandise, funeral services, or combination thereof which the licensee purports to sell, including but not limited to failing to employ or have a contractual arrangement with at least one person who is licensed to perform mortuary science services, as described in Iowa Code chapter 156.

105.6(10) *Sale of business without notice.* Selling all or part of a licensee's business without proper notice to the commissioner, pursuant to rule 191—103.3(523A).

105.6(11) *Improper sale or transfer of purchase agreements.* Selling or transferring purchase agreements as part of the sale of a business or the assets of a business, if an audit expressing the auditor's opinion of the adequacy of funding related to the purchase agreements to be sold or transferred has not been performed by a certified public accountant and filed with the commissioner, as required by Iowa Code Supplement section 523A.207.

105.6(12) *Sales prohibited by order.* The applicant or licensee has been named in an order issued pursuant to Iowa Code Supplement section 523A.807(3) as amended by 2008 Iowa Acts, House File 2555, section 52.

105.6(13) *Failure to complete continuing education.* Failure of a licensee to timely complete the continuing education required for license renewal.

105.6(14) *Law violations.* Violating any state or federal law applicable to the conduct of the applicant's or licensee's business including, but not limited to, the following:

a. The provisions of Iowa Code chapter 156 pertaining to the licensure of funeral directors in the state of Iowa;

b. Regulations promulgated by the Federal Trade Commission relating to funeral services, or funeral or cemetery merchandise, or funeral or cremation establishments;

c. Applicable tax or public health laws, ordinances or regulations; or

d. Laws, rules, ordinances, or regulations occurring outside of Iowa if the commissioner determines that such violation may adversely implicate the licensee's or applicant's compliance with Iowa laws, rules, orders, ordinances, or regulations.

105.6(15) *Unsafe practice.* Having any impairment, drug or alcohol addiction, or other act, conduct or condition which adversely impacts the licensee's ability to perform in a safe, competent manner.

105.6(16) *Failure to maintain fidelity bond or similar insurance.* A preneed seller's failure to maintain a fidelity bond or similar insurance as required by rule 105.5(523A) and Iowa Code Supplement section 523A.201(5).

105.6(17) *Responsibility for sales activities of others.* A preneed seller's consent or acquiescence to violation of 191—Chapters 100 through 106, Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, or 2008 Iowa Acts, Senate File 2349 and House File 2555, by any person acting on the preneed seller's behalf.

191—105.7(523A) Prohibition on sales activities and practices without a license or without an appointment.

105.7(1) *License required.* No person shall advertise, sell, promote, or offer to furnish cemetery merchandise, funeral merchandise, funeral services, or a combination thereof when performance or delivery may be more than 100 days following the initial payment of the account unless the person either:

a. Holds an active preneed seller license issued by the commissioner pursuant to Iowa Code Supplement section 523A.501 as amended by 2008 Iowa Acts, Senate File 2349, sections 5 and 6, and House File 2555, section 48; or

b. Holds an active sales agent license issued by the commissioner pursuant to Iowa Code Supplement section 523A.502 as amended by 2008 Iowa Acts, Senate File 2349, section 7, and House File 2555, sections 49 and 50, and the person is an appointed sales agent of a person holding a preneed seller license issued by the commissioner pursuant to Iowa Code Supplement section 523A.501 as amended by 2008 Iowa Acts, Senate File 2349, sections 5 and 6, and House File 2555, section 48.

105.7(2) *Prohibited activities.* A person to whom a license has not been issued by the commissioner, a licensee whose license has expired, is inactive, or is suspended, or a sales agent who is not appointed by a preneed seller, may not:

a. Conduct any of the activities for which a license is required pursuant to Iowa Code chapter 523A or rule 191—103.1(523A);

b. Post or display the licensee's license;

c. Use a license certificate or a license number;

d. Agree to perform any term of an agreement, whether or not pursuant to a written purchase agreement, to furnish cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, if the sale of the merchandise or services is subject to Iowa Code chapter 523A and the sale is after the renewal date of the license;

e. Execute an agreement or agree to perform any term of an agreement or, unless the agreement was entered into while the licensee had an active license issued by the commissioner, accept any payment or funding, including the assignment of ownership of or proceeds from an insurance policy or annuity, whether or not pursuant to a written purchase agreement, related to the purchase of cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, if the sale of the merchandise or services is subject to Iowa Code chapter 523A and the sale is after the renewal date of the license. This rule does not prevent payments to an unlicensed person upon the person's delivery of cemetery merchandise, funeral merchandise or funeral services after the death of a beneficiary,

including the payment of the proceeds of an insurance policy or annuity at the time of death of the insured listed on the insurance policy or annuity.

These rules are intended to implement Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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CHAPTER 106
DISCIPLINARY PROCEDURES

191—106.1(523A) Investigations. The commissioner is authorized by Iowa Code section 17A.13(1) and Iowa Code Supplement section 523A.803 to conduct such investigations as the commissioner deems necessary to determine whether any person has violated or is about to violate Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555. The commissioner is authorized to issue and enforce subpoenas to compel testimony and to compel the production of books and records, as more fully described in Iowa Code Supplement section 523A.803. Upon the commissioner's determination that probable cause exists to commence a disciplinary proceeding, the procedures contained in 191—Chapter 3 shall apply.

191—106.2(17A,523A) Penalties. Persons violating Iowa Code chapter 523A or rules adopted or orders issued pursuant thereto may be subject to one or more of the following penalties.

106.2(1) *Criminal penalties.* A person who willfully violates Iowa Code Supplement section 523A.501(1), concerning the requirement for a preneed seller license, or Iowa Code Supplement section 523A.502(1), concerning the requirement for a sales agent license, is guilty of a Class D felony. Licensed and unlicensed persons who violate other provisions of Iowa Code chapter 523A and rules adopted or orders issued pursuant to Iowa Code chapter 523A including, but not limited to, a failure to properly place trust funds into trust, pursuant to Iowa Code Supplement sections 523A.201, 523A.202, and 523A.404, and Iowa Code Supplement section 523A.405 as amended by 2008 Iowa Acts, Senate File 2349, section 4, and House File 2555, section 46, are subject to prosecution for crimes including, but not limited to, fraudulent practice under Iowa Code Supplement section 523A.703, theft under Iowa Code chapter 714, or ongoing criminal conduct under Iowa Code chapter 706A. 191—Chapters 100 through 106 do not limit the power of the state to punish any person for any conduct which constitutes a crime under any other statute.

106.2(2) *Consumer fraud Act.* A violation by a licensed or unlicensed person of Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, 2008 Iowa Acts, Senate File 2349 and House File 2555, 191—Chapters 100 through 106, or an order issued pursuant to those chapters, is a violation of the Iowa consumer fraud Act, Iowa Code sections 714.16 and 714.16A.

106.2(3) *Administrative sanctions.*

a. Pursuant to Iowa Code Supplement sections 523A.204(4) and 523A.502A, the failure of a licensee to timely file an annual report shall result in an administrative penalty of $500. The license is suspended on the date the annual report was due until the overdue report is filed and the administrative penalty paid. The licensee is not authorized to solicit or execute any purchase agreement under Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, until the license has been reinstated.

b. If the commissioner issues or renews a license and subsequently determines that payment for the license or renewal was returned by a bank without payment to the commissioner, or that the credit card company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the commissioner are paid, at which time the license may be reinstated at the request of the applicant.

c. If the commissioner issues or renews a sales agent license and subsequently determines that the sales agent is not appointed by a preneed seller, the license shall be immediately suspended until the sales agent obtains such an appointment and provides satisfactory evidence to the commissioner of the appointment, at which time the license may be reinstated at the request of the sales agent.

d. The commissioner may impose the following disciplinary sanctions, alone or in combination, against a licensee or as a condition of licensure of an applicant for an initial or renewal license:

(1) Issue a warning letter or a letter of reprimand;

(2) Require additional education or training;

(3) Order mediation pursuant to Iowa Code Supplement section 523A.804;

(4) Issue a cease and desist order pursuant to Iowa Code section 523A.805 or Iowa Code Supplement section 523A.807 as amended by 2008 Iowa Acts, House File 2555, section 52;

(5) Require certain specified procedures or methods of operation;

(6) Order the payment of consumer restitution;

(7) Place a licensee on probationary status with or without the imposition of reasonable conditions to control or monitor conduct, such as periodic reports;

(8) Refuse to issue or renew a license;

(9) Suspend a license for an indefinite or specific period of time;

(10) Revoke a license;

(11) Accept the voluntary surrender of a license;

(12) Impose costs associated with the commissioner's investigation and enforcement activities;

(13) Impose civil penalties pursuant to Iowa Code Supplement section 523A.807 as amended by 2008 Iowa Acts, House File 2555, section 52, for violation of Iowa Code Supplement section 523A.201 or 523A.202; Iowa Code Supplement section 523A.401 as amended by 2008 Iowa Acts, House File 2555, section 44; Iowa Code Supplement section 523A.402 as amended by 2008 Iowa Acts, House File 2555, section 45; Iowa Code section 523A.403; Iowa Code Supplement section 523A.404; Iowa Code Supplement section 523A.405 as amended by 2008 Iowa Acts, Senate File 2349, section 4, and House File 2555, section 46; Iowa Code Supplement section 523A.501 as amended by 2008 Iowa Acts, Senate File 2349, sections 5 and 6, and House File 2555, sections 47 and 48; or Iowa Code Supplement section 523A.502 as amended by 2008 Iowa Acts, Senate File 2349, section 7, and House File 2555, sections 49 and 50;

(14) Any other sanction allowed by law, as the commissioner deems appropriate.

e. A person with an inactive, expired, or suspended license is subject to disciplinary action, injunctive action, criminal sanctions and any other available legal remedies in the event of any violation of Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, 2008 Iowa Acts, Senate File 2349 and House File 2555, or any rules or orders adopted thereto.

f. In addition, or as an alternative to the administrative process described in these rules, the commissioner may seek an injunction in district court, refer the matter for criminal prosecution, enter into a consent agreement, issue an informal cautionary letter, refer the matter to the attorney general, or refer the matter to a licensing entity with regulatory authority and jurisdiction over the unlicensed person, such as the mortuary science board established under Iowa Code chapter 156.

g. The following factors may be considered by the commissioner in determining the nature and severity of the disciplinary sanction to be imposed:

(1) The facts of the particular violation, such as the circumstances leading to the violation, the severity of the infraction, and the clarity of the issues, laws and rules involved;

(2) Evidence that the infraction is not an isolated event and is part of a widespread practice;

(3) Evidence that the acts or practices were willful and intentional;

(4) The economic benefits gained by the licensee or applicant as a result of the infraction;

(5) Evidence that the infraction occurred while the licensee was on probation or had an inactive or suspended license;

(6) The number of prior warning letters or reprimand letters;

(7) The number of complaints;

(8) The number of prior violations, especially evidence of repetitive violations of a like kind;

(9) The seriousness of prior complaints or violations;

(10) The length of time since the unlawful practice occurred;

(11) Whether the violation involved an element of deception;

(12) Whether the unlawful practice violated a prior order of the commissioner, court order, cease and desist agreement, consent order, or similar document;

(13) Whether the person acted in bad faith;

(14) The extent to which the licensee or applicant cooperated with the commissioner;

(15) Evidence of reform or remedial action and whether reform or remedial action occurred prior to the commissioner's involvement with the fact situation;

(16) The amount of restitution paid or to be paid;

(17) The risk of harm created by the acts or practices involved in the infraction;

(18) The public interest in ensuring competency and a high standard of ethical and professional conduct by licensees;

(19) The public interest in protecting consumers and preventing the acts or practices involved in the infraction;

(20) Whether the penalty will act as a substantial deterrent and reduce the likelihood of future violations; and

(21) Any other extenuating facts or other countervailing considerations.

191—106.3(17A,523A) Administrative procedures.

106.3(1) Notice of sanctions. If the commissioner finds cause to impose a sanction against a person pursuant to Iowa Code chapter 523A or subrule 106.2(3), the commissioner shall provide notice to the person. Delivery of the notice shall be accomplished in the manner set out in 191—paragraphs 3.5(1)*"a"* and *"b."* The notice shall include the following:

a. A statement of the legal authority and jurisdiction under which the order would be issued;

b. Reference to the particular sections of the statutes and rules involved;

c. A short, plain statement of the alleged unlawful practices;

d. The dollar amount of the proposed civil penalty and the nature of the intended order to require compliance with Iowa Code chapter 523A, including any required restitution;

e. Notice of the unlicensed person's right to a hearing and the time frame in which hearing must be requested; and

f. The address to which written request for hearing must be made.

106.3(2) Requesting a hearing regarding sanctions imposed. If the commissioner imposes any administrative sanctions against a person pursuant to Iowa Code chapter 523A or subrule 106.2(3), the person may request a hearing pursuant to 191—Chapter 3 within 30 days of receipt of the notice. Applicable procedures of this chapter, of 191—Chapter 3, and of Iowa Code chapter 17A shall apply. A failure to timely request a hearing shall constitute a failure to exhaust administrative remedies. A request for hearing must be in writing and is deemed made on the date of the nonmetered United States Postal Service postmark or the date of personal delivery to the commissioner's office.

106.3(3) If a request for hearing is not timely made, the commissioner may issue an order imposing the administrative penalty and requiring compliance with Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, as described in the notice. The order may be served in the same manner as the notice of intent to impose administrative penalty, and may additionally be provided in a manner reasonably calculated to provide actual notice.

106.3(4) If a request for hearing is timely made, the commissioner shall issue a notice of hearing, following the procedures applicable to a contested case in 191—Chapter 3. Hearings are open to the public.

106.3(5) A person may waive the right to hearing and all attendant rights and enter into a consent order imposing an administrative penalty and requiring compliance with Iowa Code chapter 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555, at any stage of the proceeding upon mutual consent of the commissioner.

106.3(6) The notice of intent to issue an order and the order are public records available for inspection and copying in accordance with Iowa Code chapter 22.

106.3(7) A person aggrieved by the commissioner's issuance of an administrative order, including an order imposing a civil penalty, may seek judicial review in accordance with Iowa Code section 17A.19.

These rules are intended to implement Iowa Code chapters 17A, 22, and 523A, 2007 Iowa Acts, Senate File 559, and 2008 Iowa Acts, Senate File 2349 and House File 2555.

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